The Regulation and Quality Improvement Authority

Inspection Report

16 May 2023

Slieve Na Mon

Type of service: Nursing Home
Address: Tircur Road, Omagh, BT79 7TY
Telephone number: 028 8225 1132

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: East Eden Ltd **Responsible Individual:** Dr Una McDonald	**Registered Manager:** Mrs Joan McLaughlin **Date registered:** 23 October 2020
Person in charge at the time of inspection: Mrs Joan McLaughlin	**Number of registered places:** 60 This number includes a maximum of 39 patients in category NH-MP/MP(E) and one identified patient in category NH-LD. The home is also approved to provide care on a day basis for a maximum of eight persons.
Categories of care: Nursing (NH): DE – dementia MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years LD – learning disability	**Number of patients accommodated in the nursing home on the day of this inspection:** 58
Brief description of the accommodation/how the service operates: Slieve Na Mon is a nursing home registered to provide nursing care for up to 60 patients. The home is divided in seven units over one floor all of which are interlinked with one another over the same building. Each unit has its own shared communal sitting and dining areas and all have access to the well-appointed grounds.	

2.0 Inspection summary

An unannounced inspection took place on 16 May 2023, from 9.45am to 1.30pm. This 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.

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 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.

The outcome of this inspection concluded that the areas for improvement identified at the last inspection had been addressed. One new area for improvement was identified in relation to the management of medicines for new admissions.

Whilst an area for improvement was identified, 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. The inspector 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 nursing staff, the deputy manager, the manager and the regional 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. Nine questionnaires were returned and all said that they were satisfied or very satisfied with the care provided in Slieve Na Mon.

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 7 June 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 27(4)(a) **Stated:** First time	The registered person shall submit a time bound action plan to the home's aligned estates inspection detailing how the recommendations from the fire safety risk assessment dated, 9 September 2021, will be addressed.	**Met**
	Action taken as confirmed during the inspection: Confirmation received from estates inspector that this was completed 5 July 2022.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 28 **Stated:** First time	The registered person shall ensure that safe systems are in place for the management of insulin.	**Met**
	Action taken as confirmed during the inspection: Safe systems were in place for the management of insulin. The date of opening was recorded on all in use insulin pen devices. No administration records had been pre populated and no doses had been pre prepared. Care plans were in place to direct staff.	

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 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 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 for 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 for six patients. 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 for six patients. Speech and language assessment reports were in place for all patients reviewed. Care plans were in place for five of the patients reviewed and the manager gave an assurance that the remaining care plan would be updated immediately following the inspection. 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. 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.

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. All of the records were found to have been fully and accurately completed. The records were filed once 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.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Written consent and care plans were in place when this practice occurred.

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 boxed 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.

Review of medicines for patients who had a recent hospital stay and were discharged back to this home, showed that hospital discharge letters had been received and a copy had been forwarded to the patient' GPs. The patients' personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. However, for one patient the medicines administration records had not been updated to reflect the changes made in hospital and staff had not followed up a discrepancy on the discharge letter. An area for improvement was identified.

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.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, an audit discrepancy was observed in the administration of one medicine. This was highlighted to the manager for investigation and close monitoring.

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.

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.

6.0 Quality Improvement Plan/Areas for Improvement

An 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	1	0

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Joan McLaughlin, Registered Manager and Ms Marlene Featherstone, Regional 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 (4) **Stated:** First time	The registered person shall review the process for the management of medicines for new admissions and for patients returning from hospital to ensure safe systems are in place. Ref: 5.2.4
To be completed by: Immediate and ongoing (16 May 2023)	**Response by registered person detailing the actions taken:** Two staff now always check in a residents medications when they return from hospital or is a new admission. staff are advised to ensure this is protected time with no disturbance. Any errors identified between discharge letter and medication dispensed are to be reported by to the discharging ward for proper clarification and correction - this is to be done on the same day pt received in. This is now been managed efficiently and effectively. An oversight audit is also carried out by the manager/deputy manager within 24hrs of arrival of the resident in the home.

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