The Regulation and Quality Improvement Authority

Inspection Report

29 November 2021

Slieve Na Mon

Type of service: Nursing Home (NH)
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 Kayleigh Hunniford – Regional Quality Manager	**Number of registered places:** 60 A maximum of 39 patients in category NH-DE and 20 patients in category NH-MP/MP(E), 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 Home (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 residential care home on the day of this inspection:** 56
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 60 patients. The home is divided into seven inter-linking units over one floor. Each unit has its own dining room, communal lounges and access to a well-appointed garden.	

2.0 Inspection summary

An unannounced inspection took place on 29 November 2021 between 10.45am and 2.45pm. The inspection was conducted by a pharmacist inspector and focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care and medicines management inspections.

Review of medicines management found that patients were being administered their medicines as prescribed.

Arrangements were in place to ensure staff were trained and competent to manage medicines. Medicines were stored safely and securely and arrangements were in place to audit medicines. Two areas for improvement in relation to records for the administration of thickening agents and the safe management of insulin were identified.

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. To complete the inspection 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 were reviewed.

4.0 What people told us about the service

The inspector met with two nurses and the regional quality manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed. Staff were warm and friendly and it was evident from their interactions 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 regional quality 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 1 July 2021		
Action required to ensure compliance with the Care Standards for Nursing Homes – April 2015		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 39 **Stated:** First time	The registered person shall ensure that all staff are in receipt of Deprivation of Liberty training – Level 2.	**Met**
	Action taken as confirmed during the inspection: All staff were in receipt of Deprivation of Liberty training – Level 2. Records of staff training were readily available for 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 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, 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 are written and updated to provide a double check 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 safe practice.

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, self-administration 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 nurses 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 nurses 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 for three patients. 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. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available. 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. Nurses 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 for three patients was reviewed. A speech and language assessment report and care plan was in place for each patient. Records of prescribing including the recommended consistency level were maintained. However, records of the administration of thickening agents including the recommended consistency were not maintained. An area for improvement was identified.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail in the care plan to direct staff if the patient's blood sugar was too low.

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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the disposal of medicines. Records were maintained and were available for review.

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. A sample of these records was reviewed. The records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for review.

Supplementary insulin administration records were in place for patients' administered insulin to manage their diabetes. Review of a sample of these records found some had been pre-populated with the prescribed insulin dose for future doses to be administered the next day. Insulin which was to be administered at lunch-time had been drawn up ready for administration and left in the medicines trolley following the morning medicines round. The date of opening was not consistently recorded on in-use insulin pens to facilitate audit and disposal at expiry. An area for improvement was identified.

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 are recorded in a controlled drug record book. Robust arrangements for the management of controlled drugs were in place.

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 safe practice.

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. Some of the practices followed by staff to assist administration mean that medicines are being administered outside the terms of their product licence. This means that the way the medicine is given has been changed to meet the need to the patient. While this is appropriate for most patients, this practice should be checked to ensure that the patient's GP agrees. Written authorisation from the GP had been obtained when this practice occurred.

The medicine cups used to administer medicines to residents were labelled as single use. Therefore, they should be discarded after each use. Staff advised that the cups are sterilised after use and reused. This matter was discussed with the regional quality manager following the inspection who gave an assurance that the necessary arrangements would be made to ensure this practice is stopped.

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 management of medicines for one patient who was admitted to the home from hospital was reviewed. A hospital discharge letter had been received and a copy had been forwarded to the patient's GP. The patient's personal medication record had been updated and medicines had been accurately received into the home and administered in accordance with the most recent 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.

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 audits completed at the inspection indicated that patients were being administered their medicines 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 staff are supported. Policies and procedures should be up to date and readily available for staff.

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 in relation to medicines management.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include records for the administration of thickening agents and the safe management of insulin.

Whilst two areas for improvement were identified, RQIA can conclude that overall patients were being administered their medicines as prescribed by their GP.

RQIA would like to thank the patients and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Care Standards for Nursing Homes, April 2015.

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Kayleigh Hunniford, Regional Quality Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes – April 2015	
Area for improvement 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (29 November 2021)	The registered person shall ensure that records of the administration of thickening agents including the recommended consistency level are maintained. Ref: 5.2.1
	Response by registered person detailing the actions taken: There is now a recording sheet capturing all occassions where thickener is administered to a resident. Form shown to inspector at time of inspection. Competencies with regards to thickener administration have been undertaken with all staff. Records maintained to reflect training.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (29 November 2021)	The registered person shall ensure that safe systems are in place for the management of insulin. Ref: 5.2.3
	Response by registered person detailing the actions taken: supervision carried out with all relevant staff on the correct administration of insulin. staff signed when supervision completed. safety notice reminder issued into fron of medicine file. insulin auditing has commenced to ensure correct protocol is being followed.

Please ensure this document is completed in full and returned via the Web Portal

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