Inspection Report
3 September 2020

County Care Home

Type of Service: Nursing Home (NH)
Address: 42 Tempo Road, Enniskillen, BT74 6HR
Tel No: 028 6632 3845
Inspector: Paul Nixon

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a registered nursing home which provides care for up to 52 patients.

2.0 Service details

Organisation/Registered Provider: EBBAY Ltd **Responsible Individual:** Mr Patrick Anthony McAvoy	**Registered Manager and date registered:** Mrs Caroline McCrea Registration pending
Person in charge at the time of inspection: Mrs Caroline McCrea	**Number of registered places:** 52
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. A maximum of 21 patients in category NH-DE. The home is also approved to provide care on a day basis to 5 persons. There shall be a maximum of 1 named resident receiving residential care in category RC-I and 1 named resident receiving residential care in category RC-PH	**Number of patients accommodated in the nursing home on the day of this inspection:** 50

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 3 September 2020 from 09.40 to 14.20.

This inspection focused on medicines management within the service. The inspection also assessed progress with any areas for improvement identified since the last medicines management inspection.

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:

- staff medicines management competency and capability assessments
- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug record book
- care records for three patients requiring a modified diet
- care records for two patients prescribed regular analgesia
- care records for three patients prescribed medication for administration on a “when required” basis for the management of distressed reactions
- medicines audits.

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Caroline McCrea, Manager, as part of the inspection process and can be found in the main body of the report.

5.0 What has this service done to meet any areas for improvement made at or since the last medicines management inspection on 24 July 2017 and care inspection on 13 February 2020?

There were no areas for improvement made at or since the last medicines management inspection on 24 July 2017 and the last care inspection on 13 February 2020.

6.0 What people told us about this service

Good relationships between staff and patients were observed. Staff were warm and friendly and it was obvious that they knew the patients well. Some patients in the general nursing unit were relaxing in the lounge and enjoying entertainment provided by two local singers. Several staff joined in the activity.

On the day of inspection we spoke with three members of staff. They said that the patients were well looked after and expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after patients and meet their needs.

Feedback methods also 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. No questionnaires were returned within the timeframe for inclusion in this report.

7.0 Inspection findings

7.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in care 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 may be done by the GP or the pharmacist.

All patients in the home were registered with a local GP and medicines were reviewed and dispensed by the community pharmacist.

Personal medication records were in place for each patient. These contained a list of all 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, transfers to hospital. These records had been fully and accurately completed. In line with best practice, a second member of staff checked and signed these records when they are updated to provide a double check that they are accurate.

The times of administration printed on the personal medication records did not always correlate with those printed on the medicine administration record sheets. The manager gave an assurance that this would be rectified without delay.

Copies of patients' prescriptions are retained in the home so that any entry on the personal medication record can be checked against the prescription. This again contributes to confidence that the systems in place are safe.

Satisfactory systems were in place for the management of pain, warfarin and thickening agents.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Care plans were in place. Directions for use were clearly recorded on the personal medication records. The reason and outcome of administration were mostly recorded in the daily care records.

7.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines must be available to ensure that they are administered to patients as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

The records inspected showed that medicines were available for administration when patients required them. The manager and registered nurses advised that there was 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. They were tidy and organised so that medicines belonging to each patient could be easily located. The medicines currently in use were stored within medicine trolleys that were also securely stored so that there could be no unauthorised access. Controlled drugs were stored in the controlled drug cabinets. When medicines needed to be stored at a colder temperature, they were stored within the medicine refrigerators and the temperature of these refrigerators were monitored.

Medicines disposal was discussed with the manager and registered nurses. They advised that medicines were denatured by two registered nurses when out-of-date or no longer needed. Disposal of medicine records were completed so that all medicines could be accounted for.

7.3 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 record sheets when medicines are administered to a patient. A sample of these records was reviewed which found that they had been fully and accurately completed.

The manager and registered nurses audit medicine administration on a regular basis within the home. The audits showed that medicines had generally been given as prescribed. The date of opening was recorded on medicines so that they could be easily audited; this is good practice.

Audits completed during this inspection also showed that medicines had been given as prescribed.

7.4 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 on admission to the home for two patients. For one of the patients, a hospital discharge letter had been received and a copy had been forwarded to the patients' GP. For the other patient, the prescribed medicines had been confirmed in writing with the GP practice. Personal medication records had been accurately written. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

7.5 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 that 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. The manager was familiar with the type of incidents that should be reported.

There had been some medication related incidents identified since the last medicines management inspection. There was evidence that the incidents had been investigated and learning had been shared with staff. The incidents had been reported to the prescribers for guidance and to the appropriate authorities including RQIA.

7.6 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.

Staff in the home had received a structured induction which included medicines management when that forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

8.0 Evaluation of Inspection

This inspection sought to assess if the home was delivering safe, effective and compassionate care and if the service was well led.

The outcome of this inspection resulted in no areas for improvement being identified. We can conclude that patients and their relatives can be assured that medicines are well managed within the home.

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

9.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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