

Inspection Report

30 April 2021



Glenmachan Tower House

Type of service: Nursing Home
Address: 13 Glenmachan Road, Belfast, BT4 2NL
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Church of God - Glenmachan Responsible Individual(s): Dr Albert Alan Stephens	Registered Manager: Mrs Helen Jane Murphy Date registered: 1 April 2005
Person in charge at the time of inspection: Mrs Helen Jane Murphy	Number of registered places: 39
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	Number of patients accommodated in the nursing home on the day of this inspection: 25
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for up to 39 patients.	

2.0 Inspection summary

An unannounced inspection took place on 30 April 2021 between 10.00am and 2.20pm. The inspection was carried out by a pharmacist inspector.

The inspection focused on medicines management within the home.

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.

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 previous inspection findings, incidents and correspondence.

To complete the inspection we reviewed: 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.

During the inspection the inspector:

- 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

4.0 What people told us about the service

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

In order to reduce the footfall throughout the home, the inspector did not meet with any patients. Patients observed during the inspection seemed content. Staff were warm and friendly and it was evident from their interactions that they knew the patients well.

Nurses 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. They spoke highly of the support given by management.

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, one questionnaire had been returned from a relative. Their responses indicated that they were “very satisfied” with all aspects of care.

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 3 September 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
<p>Area for improvement 1</p> <p>Ref: Regulation 13 (7)</p> <p>Stated: First time</p>	<p>The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk and spread of infection.</p> <p>This is made in reference but not limited to the correct use of PPE.</p> <p>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.</p>	<p>Carried forward to the next inspection</p>
<p>Area for improvement 2</p> <p>Ref: Regulation 12(1) (a) (b)</p> <p>Stated: First time</p>	<p>The registered person shall ensure that the following is in place for wound care:</p> <ul style="list-style-type: none"> The wound care plan includes the required frequency of the dressing regimen. Nursing staff record all wound care interventions in an accurate, thorough and consistent manner in compliance with legislative and best practice standards. <p>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.</p>	
<p>Area for improvement 3</p> <p>Ref: Regulation 13 (1) (a) (b)</p>	<p>The registered person shall ensure that all unwitnessed falls are managed in line with best practice guidance and that neurological observations are recorded accordingly.</p>	<p>Carried forward to the next inspection</p>

Stated: First time	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 summary
Area for improvement 1 Ref: Standard 35 Stated: First time	The registered person shall develop a system to ensure that checks are being conducted on a regular basis in relation to staff's registration status; this was made in reference but not limited to the NMC registrations. 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.	Carried forward to the next inspection
Area for improvement 2 Ref: Standard 4 Stated: First time	The registered person shall ensure that robust patient centred care plans are in place for each patient's assessed need, with specific reference to mobility. 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 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 a GP, a 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 majority of personal medication records reviewed 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 provide a double check that they were accurate. A small number of records had not been signed by two nurses and this was brought to the attention of the manager for corrective action. The manager was also reminded that the date of writing should be recorded on the personal medication records.

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.

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 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 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. Care plans directing the use of these medicines were available in the patients' files. 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. Records of administration, including the reason for and outcome of administration were recorded.

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. Care plans were in place and there was evidence that they were 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 patients.

The management of thickening agents was reviewed. Care plans and speech and language assessments were available. However, records of prescribing and administration which included the recommended consistency level were not maintained for all designated patients. This is necessary to ensure that nurses and care assistants are able to refer to the current recommendations at each administration and so that there is evidence the thickening agent is being administered as prescribed. 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 tube. The management of medicines and nutrition via the enteral route was reviewed. A regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. However, this did not correlate with the personal

medication records and daily fluid intake charts. Some fluid intake charts had not been totalled each day and it was unclear if the recommended daily fluid intake had been achieved. The manager was requested to review these records on the day of the inspection to ensure that the recommended regimen was adhered to and that records of prescribing and administration were accurately maintained. An area for improvement was identified.

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

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patients' 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.

Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner. With the exception of one medicine (a nutritional supplement) the records inspected showed that medicines were available for administration when patients required them. The nutritional supplement had been out of stock since 9 April 2021. The manager advised that she had identified this out of stock on 29 April 2021 and that the nutritional supplement had been ordered. Assurances were provided that the patient had not lost weight and was eating well. The registered person must ensure that all nurses are aware for their accountability in ensuring that medicines are available for administration on all occasions. Any potential out of stocks must be followed up without delay. An area for improvement was identified.

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. Medicines which required cold storage were stored in a medicine refrigerator.

Nurses were reminded that in-use insulin pens should be individually labelled and dated when opened to facilitate audit and disposal at expiry. It was acknowledged that all but one insulin pen were labelled and dated on opening.

Appropriate arrangements were in place for the disposal of medicines. It was agreed that two nurses would sign the disposal records from the date of the inspection onwards.

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. Most of the records were found to have been fully and accurately completed (see section 5.2.1). The records were filed once completed and were readily retrievable to facilitate audit and review.

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 observed to be clearly recorded in a controlled drug record book. One recording error was brought to the attention of the nurse on duty for correction.

Management and staff audited medicine administration on a regular basis. 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 at the inspection indicated that the majority of medicines were being administered as prescribed. Audit discrepancies were observed in the administration of a small number of medicines and these were brought to the attention of the manager for ongoing monitoring.

The medicine cups used to administer medicines to patients were labelled as single use. Therefore, they should be discarded after each use. However, the manager and staff advised that the cups are washed after use and then reused. This matter was discussed with the manager who gave an assurance that this practice would stop.

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 on admission/re-admission to the home was reviewed for two patients. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. The patients' personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home.

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.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. 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.

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.

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 Conclusion

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

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 record keeping and the management of one out of stock.

Although three areas for improvement were identified, we can conclude that overall, the patients were being administered their medicines as prescribed.

We 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 where action is required to ensure compliance with the Nursing Home Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, April 2015.

	Regulations	Standards
Total number of Areas for Improvement	6*	2*

* The total number of areas for improvement includes three under the regulations and two under the standards which have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Helen Murphy, Registered 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (7) Stated: First time To be completed by: Immediately and ongoing	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk and spread of infection. This is made in reference but not limited to the correct use of PPE.
	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 12(1) (a) (b) Stated: First time To be completed by: Immediately and ongoing	The registered person shall ensure that the following is in place for wound care: <ul style="list-style-type: none"> • The wound care plan includes the required frequency of the dressing regimen. • Nursing staff record all wound care interventions in an accurate, thorough and consistent manner in compliance with legislative and best practice standards.
	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 3 Ref: Regulation 13 (1) (a) (b) Stated: First time To be completed by: Immediately and ongoing	The registered person shall ensure that all unwitnessed falls are managed in line with best practice guidance and that neurological observations are recorded accordingly.
	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

<p>Area for improvement 4</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: Immediately and ongoing</p>	<p>The registered person shall ensure that records of prescribing and administration of thickening agents, including the recommended consistency level are maintained.</p> <p>Ref 5.2.1</p> <p>Response by registered person detailing the actions taken: The recommended consistency level of thickening is now on intake charts and staff sign when administered.</p>
<p>Area for improvement 5</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: Immediately and ongoing</p>	<p>The registered person shall ensure that clear records for the prescribing and administration of nutrition and fluids via the enteral route are maintained. Fluid intake charts should be totalled each day.</p> <p>Ref 5.2.1</p> <p>Response by registered person detailing the actions taken: All records for the prescribing and administration of nutrition and fluids via enteral route have been ammended to clearly reflect dietician's advice and are totalled each day.</p>
<p>Area for improvement 6</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: Immediately and ongoing</p>	<p>The registered person shall ensure that all nurses are aware of their accountability in ensuring that medicines are available for administration on all occasions. Any potential out of stocks must be followed up without delay.</p> <p>Ref 5.2.2</p> <p>Response by registered person detailing the actions taken: All nursing staff have completed an update on administration of medicines to include monitoring of medicines in stock and timely reordering of medicine.</p>
<p>Action required to ensure compliance with Care Standards for Nursing Homes, April 2015</p>	
<p>Area for improvement 1</p> <p>Ref: Standard 35</p> <p>Stated: First time</p> <p>To be completed by: 30 October 2020</p>	<p>The registered person shall develop a system to ensure that checks are being conducted on a regular basis in relation to staff's registration status; this was made in reference but not limited to the NMC registrations.</p> <p>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.</p> <p>Ref: 5.1</p>

Area for improvement 2 Ref: Standard 4 Stated: First time To be completed by: 1 November 2020	The registered person shall ensure that robust patient centred care plans are in place for each patient's assessed need, with specific reference to mobility.
	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

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



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