Inspection Report

2 November 2022

Greerville Manor Care Home

Type of service: Nursing Home
Address: 192 Newtownbreda Road, Belfast, BT8 6QB
Telephone number: 028 9064 4244

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: Beaumont Care Homes Limited **Responsible Individual:** Mrs Carol Cousins	**Registered Manager:** Ms Joy Cruz Cristobal **Date registered:** 20 November 2020
Person in charge at the time of inspection: Ms Joy Cruz Cristobal	**Number of registered places:** 60 This number includes: A maximum of 28 patients in category NH-DE accommodated in the Dixon Unit. A maximum of 15 patients in category NH-A accommodated in the Belvoir Unit. A maximum of 16 patients in categories NH-MP/MP(E) and 1 named resident in category RC-MP accommodated in Millbrook Unit.
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 A – past or present alcohol dependence	**Number of patients accommodated in the nursing home on the day of this inspection:** 59
Brief description of the accommodation/how the service operates: Greerville Manor Care Home is a registered nursing home which provides nursing care for up to 60 patients. The home is divided into three units; the Dixon Unit provides care for patients with dementia, the Belvoir Unit provides care for patients with alcohol related brain injury and the Millbrook Unit provides care for patients with a mental health disorder. Within each unit patients have access to communal lounges, dining rooms and enclosed gardens.	

2.0 Inspection summary

An unannounced inspection took place on 2 November 2022, from 10.15am to 3.15pm. This was completed by a pharmacist inspector 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 were well maintained and medicines were stored safely and securely. 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. One new area for improvement was identified in relation to the management of medicines for distressed reactions. Details of the area for improvement can be found in the quality improvement plan.

Whilst one new area for improvement was identified; based on the inspection findings and discussions held, RQIA 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 management team.

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 to staff and management about how they plan, deliver and monitor the management of medicines within the home.

4.0 What people told us about the service

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

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. At the time of issuing this report, one completed relative questionnaire had been received by RQIA. The respondent indicated they were very satisfied with the level of care their relative received.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

The last inspection of this nursing home was undertaken on 26 August 2021 by a care inspector; no areas for improvement were identified.

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 nurses 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. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain /infection. However, one of the care plans reviewed required updating

to reflect the latest medicines prescribed. On occasions, when these medicines were administered to patients in the Millbrook Unit, the reason for and outcome of each administration was not recorded. An area for improvement was identified.
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. However, for one of the three patients whose records were reviewed, a pain management care plan directing the use of the prescribed pain medicine was not in place. The manager gave an assurance this would be immediately addressed following the inspection.

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 were reviewed for three patients. A speech and language assessment report and care plan was in place for each patient. 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 of the recommended range.

Warfarin is a high risk medicine and therefore safe systems must be in place to ensure patients are administered the prescribed dose and arrangements are in place for regular blood monitoring. The management of warfarin was reviewed. The latest INR blood result and prescribed warfarin dose were accurately recorded and readily available for review warfarin had been administered as prescribed and records of the administration accurately maintained.

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. Medicine refrigerators and controlled drugs cabinets 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. The records reviewed 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 were recorded in the controlled drug record books. There were satisfactory arrangements 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.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed and audits completed by the inspector showed that the medicines had been administered as prescribed.

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 medicines were being administered as prescribed. A small number of discrepancies were highlighted to the manager for 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. Policies and procedures should be up to date and readily available for staff reference.

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. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The area for improvement and details of the Quality Improvement Plan were discussed with Ms Joy Cristobal, 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 Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (2 November 2022)	The registered person shall review the management of medicines prescribed for distressed reactions to ensure that: - a care plan is in place to direct care which includes the name of the prescribed medicine(s) - the reason for and outcome of administering the medicine(s) is recorded. Ref: 5.2.1
	Response by registered person detailing the actions taken: Care files and records have been reviewed, updated and audited to confirm that they include specific details on client's medications prescribed for the management of distressed reactions. Auditing and spot checking of these records will continue on a rolling plan to support the sustainment of these improvements. The reason for and outcome of administering medication is recorded on supplementary documentation held with the medication kardex/MAR sheet along with the care plan evaluation. These records will be spot checked by the Home Manager/designated other and recorded to support the required monitoring and evaluation processes are in place. This area for improvement will be reviewed by the aligned Senior Manager when completing the Regulation 29 visit.

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

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