The Regulation and Quality Improvement Authority

Inspection Report

4 April 2023

Balmoral View Care Home

Type of service: Nursing Home
Address: 5 The Manor, Blacks Road, Dunmurry, BT10 0NB
Telephone number: 028 9062 9331

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 Ruth Burrows	**Registered Manager:** Ms Debby Gibson **Date registered:** 29 December 2022
Person in charge at the time of inspection: Ms Debby Gibson	**Number of registered places:** 39 This number includes a maximum of 15 patients in category NH-DE to be accommodated in the dementia unit. Category NH-MP for one named patient only. There shall be a maximum of one named resident receiving residential care in category RC-I.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia MP – mental disorder excluding learning disability or dementia 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:** 38
Brief description of the accommodation/how the service operates: Balmoral View Care Home is a registered nursing home which provides nursing care for up to 39 patients. The home is divided into two units; the Suffolk Suite which provides care for people with dementia and the Coleman Suite which provides general nursing care. Patients' bedrooms are located over three floors.	

2.0 Inspection summary

An unannounced inspection took place on 4 April 2023, from 10.15am to 3.30pm. 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.

The areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection.

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 maintaining accurate personal medication records, obtaining written confirmation of medicines for new admissions and ensuring that medicines are prepared immediately prior to administration.

Whilst areas for improvement were identified, it was concluded that overall 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 to 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 inspector met with the care home assistant practitioner (CHAP), nursing staff, the deputy manager and the 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. 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 3 and 4 May 2022		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure evaluations of wound care are recorded in the patient's daily progress notes.	**Carried forward to the next inspection**
	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.	
Area for improvement 2 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure that where a patient's daily fluid intake was inconsistent with the desired daily target on a consecutive number of days that records are maintained to evidence action taken by nursing staff.	**Carried forward to the next inspection**
	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.	
Area for improvement 3 **Ref:** Standard 23.5 **Stated:** First time	The registered person shall ensure that the system in place to monitor pressure mattress settings in the home is effective.	**Carried forward to the next inspection**
	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 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.

Some of the personal medication records reviewed at the inspection were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. Obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient. An area for improvement was identified.

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 two patients. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. The manager provided an assurance that one identified care plan would be updated immediately following the inspection to reflect the most recent prescribed dose. 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. A speech and language assessment report and care plan was in place. 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.

It is important that nurses follow safe medication administration processes to ensure that medicines are administered to the right patient at the right time. This includes administering medicines to each patient directly from their dispensed supply and signing the record of administration immediately after the medicine has been administered to the specific patient. Failure to follow this process may mean that medicines are administered to the wrong patient in error.

It was observed that one medicine due for administration at the next medicine round had been prepared in advance. This practice is unsafe. This was brought to the attention of the nurse, the deputy manager and the manager to address urgently. Nurses must follow safe systems for the administration of medicines. 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 should be recorded in the controlled drug record book. 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 not in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was not obtained at or prior to admission for one patient and it could therefore not be determined if the patient was being administered all of their prescribed medicines. The personal medication record for a recent admission was inaccurate. 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 medicines were being administered 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 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

Areas for improvement have 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	3	3*

* The total number of areas for improvement includes three which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Debby Gibson, Registered Manager and Ms Tanya Brannigan, Deputy 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 (4) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection (4 April 2023)	The registered person shall ensure that personal medication records are accurate with the most up to date prescribed medication and that obsolete records are cancelled and archived. Ref: 5.2.1
	Response by registered person detailing the actions taken: A review of all personal medication records was carried out following the inspection, all records are now up to date and all obsolete records have been cancelled and archived. Supervisions were completed with all trained staff in relation to Medication Management and the need to ensure all personal medication records are accurate and contain the most up to date prescribed medication. This was also discussed at the trained staff meeting held on 25.04.2023 and also at the Sisters meeting on 05.05.2023. Ongoing monitoring will continue in the form of weekly checks by the Deputy Manager / Home Manager and as part of the monthly Regulation 29 visit.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection (4 April 2023)	The registered person shall ensure that medicines are prepared immediately prior to administration for each patient and the record of administration signed immediately after. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Home Manager and Deputy Manager discussed the implications of the pre-dispensing of medications with the member of staff concerned. A supervision was completed with all trained staff and the issue was discussed at the trained staff meeting on 25.04.2023. A reflective account was provided by the member of staff concerned. Ongoing monitoring will continue during the daily walk rounds by the Deputy Manager / Home Manager and as part of the monthly Regulation 29 visit.

Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection (4 April 2023)	The registered person shall ensure that written confirmation of all new patients' medicines is obtained from the prescriber at or prior to admission to the home and that medicine records are accurately completed. Ref: 5.2.4
	Response by registered person detailing the actions taken: Written confirmation of the identified patients' medications has been obtained. Supervisions were completed with all trained staff in relation to Medication Management and the need to have confirmation of a new resident's medication prior to admission whether this is in the form of a discharge letter from hospital or confirmation from the GP surgery. This issue was discussed at the trained staff meeting held on 25.04.2023 and also at the Sisters meeting on 05.05.2023 Ongoing monitoring will continue in the form of weekly checks completed by the Deputy Manager / Home Manager and as part of the monthly Regulation 29 visit.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 12 July 2021	The registered person shall ensure evaluations of wound care are recorded in the patient's daily progress notes.
	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
Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect (4 May 2022)	The registered person shall ensure that where a patient's daily fluid intake was inconsistent with the desired daily target on a consecutive number of days that records are maintained to evidence action taken by nursing staff.
	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

Area for improvement 3 **Ref:** Standard 23.5 **Stated:** First time **To be completed by:** With immediate effect (4 May 2022)	The registered person shall ensure that the system in place to monitor pressure mattress settings in the home is effective.
	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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care