The Regulation and Quality Improvement Authority

Inspection Report

6 April 2023

Movilla House

Type of service: Nursing Home
Address: 51 Movilla Road, Newtownards, BT23 8RG
Telephone number: 028 9181 9399

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: Movilla House Ltd **Responsible Individual:** Mr Derek Alfred Bell	**Registered Manager:** Mrs Michaela Campbell **Date registered:** Registration pending
Person in charge at the time of inspection: Mrs Michaela Campbell	**Number of registered places:** 50
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:** 42
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide nursing care for up to 50 patients.	

2.0 Inspection summary

An unannounced inspection took place on 6 April 2023, from 10.20am to 3.00pm. The inspection was completed by a pharmacist inspector. The inspection 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.

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 inspection.

Review of medicines management found that patients were being administered their medicines as prescribed. Arrangements were in place to ensure that staff were trained and competent in medicines management. Medicines were stored securely. However, areas for improvement were identified in relation to the management of medication changes, record keeping, care planning for patients with diabetes and the audit process.

RQIA would like to thank the patients and 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 the home was 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 the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with 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 one nurse, one nursing sister and the manager.

Staff were warm and friendly and it was evident from discussions that they knew the patients well.

The staff members spoken with said that they had the appropriate training and felt supported to be able to deliver safe care.

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 31 January 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 20 (3) **Stated:** First time	The registered persons shall ensure that any nurse taking charge of the home in the absence of the manager has completed a nurse in charge competency and capability assessment.	**Carried forward to the next inspection**
	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**
Area for Improvement 1 **Ref:** Standard 46 **Stated:** First time	The registered persons shall ensure that communal bathrooms are maintained clutter free and clinical waste bags are managed in accordance with regional IPC guidance.	**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 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, for example, at medication reviews or hospital appointments.

The majority of personal medication records reviewed at the inspection were accurate and up to date. In line with safe practice, a second nurse had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. However, some personal medication records needed to be re-written due to the number of medication changes. In addition, some recent medication changes had not been recorded on the personal medication records and several obsolete personal medication records remained available on the medicines file. Obsolete personal medication records should be cancelled and archived to ensure that they are not referred to in error. An area for improvement was identified.

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 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 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 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. 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, infection or constipation. Directions for use were clearly recorded on the personal medication records. Care plans directing the use of these medicines were available. Records of administration had been accurately maintained. The reason for and outcome of administration had been recorded on most occasions. It was agreed that this would be discussed with nurses and on-going compliance monitored through the audit process. (See Section 5.2.3)

The management of pain was reviewed. Nurses 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. There was evidence that analgesia was administered as prescribed.

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 for three patients. Speech and language assessment reports and care plans were in place. Records of prescribing did not include the consistency level; this was updated at the inspection.

Records of administration, which included the recommended consistency level, were maintained. It was agreed that this would be discussed with nurses and followed up through the audit process (See Section 5.2.3).

Care plans were in place when patients required insulin to manage their diabetes. However, the care plans did not contain sufficient detail to direct staff if the patient's blood sugar was outside their target range. An area for improvement was identified.

The management of warfarin (a high risk medicine) was reviewed. Dosage directions were received in writing and the audits completed at the inspection identified that warfarin was administered as prescribed. However, obsolete dosage directions had not been cancelled and archived. This was actioned at the inspection. The manager advised that this would be discussed with all nurses and compliance monitored through the audit process (See Section 5.2.3).

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.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. Satisfactory recordings were observed for the temperature of the treatment rooms and medicines refrigerators on the date of the inspection. However, a review of previous records indicated that the refrigerator temperature was sometimes less than 2^{o}C. The manager advised that this would be discussed with all staff and monitored as part of the home's audit process (See Section 5.2.3).

Appropriate arrangements were in place for the 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.

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 had been completed in a satisfactory manner.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The records of receipt, administration and disposal of controlled drugs were maintained to the required standard in a controlled drug record book. Nurses were reminded that entries in the controlled drug record must not be amended.

Running stock balances were maintained for medicines which were not supplied in the monitored dosage system. The audits completed at the inspection indicated that medicines were administered as prescribed.

A review of the home's audits indicated that they did not identify some of the issues highlighted at this inspection. The registered person should implement a robust audit tool which covers all aspects of medicines management including: the standard of maintenance of the personal medication records, distressed reactions, insulin, warfarin, thickening agents, refrigerator temperatures and the management of medication changes. An area for improvement was identified.

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.

Review of medicines for patients who had a recent hospital stay and were discharged back to this home, showed that 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 and administered in accordance with the most recent directions. However, staff had amended the contents of the monitored dosage system by adding new medication and removing discontinued medication. This practice is unsafe. Robust systems must be in place for the management of medication changes. 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.

The medicine related incident which had been reported to RQIA since the last inspection was discussed. There was evidence that the incident had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

Guidance on identifying and reporting incidents was provided during the inspection to ensure that all staff were aware of the types of medication incidents which must be reported to RQIA.

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 staff are competent in managing medicines and they are supported. Policies and procedures should be up to date and readily available for staff.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Update training and competency assessment was completed annually or more frequently if a need was identified. Medicines management policies and procedures were in place.

The manager advised that the findings of this inspection would be shared with all staff for ongoing improvement.

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 and the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	2*	4*

* The total number of areas for improvement includes two that have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Michaela Campbell, 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 20 (3) **Stated:** First time **To be completed by:** 28 February 2023	The registered persons shall ensure that any nurse taking charge of the home in the absence of the Manager has completed a Nurse in Charge competency and capability assessment.
	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 13 (4) **Stated:** First time **To be completed by:** With immediate effect (6 April 2023)	The registered person shall ensure that safe systems are in place for the management of medication changes. Ref: 5.2.4
	Response by registered person detailing the actions taken: Standard operating procedures for the management of medication changes have been updated and communicated to the Nursing Team.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for Improvement 1 **Ref:** Standard 46 **Stated:** First time **To be completed by:** With immediate effect (31 January 2023)	The registered persons shall ensure that communal bathrooms are maintained clutter free and clinical waste bags are managed in accordance with regional IPC guidance.
	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 29 **Stated:** First time **To be completed by:** With immediate effect (6 April 2023)	The registered person shall ensure that personal medication records are accurate, up to date, and cancelled and archived in a timely manner. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Nursing Team have re-written their named resident's Personal medication records and check weekly that any

	obsolete prescriptions and medication records are cancelled and archived in the resident's files. This has been added to the weekly medication audit checks.
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** With immediate effect (6 April 2023)	The registered person shall ensure that care plans for the management of diabetes contain sufficient detail to direct the required care. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Diabetes Care Plan template has been updated to include actions to be taken if a resident's blood sugar is outside of normal range; both if it is high or low.
Area for improvement 4 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 6 May 2023	The registered person shall implement a robust audit tool which covers all aspects of medicines management. Ref: 5.2.3
	Response by registered person detailing the actions taken: Weekly and quarterly medication audits have been updated to include checks that medications prescribed on the resident's Kardex match the daily administration (MAR) Sheets and that all obsolete prescription sheets are cancelled and archived.

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

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