The Regulation and Quality Improvement Authority

Inspection Report

8 October 2021

Our Lady's Home

Type of service: Nursing Home
Address: 68 Ard-Na-Va Road,
Falls Road, Belfast
BT12 6FF
Telephone number: 028 9032 5731

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: Macklin Care Homes Limited **Responsible Individual:** Mr Brian Macklin	**Registered Manager:** Ms Isabel Neves - Acting
Person in charge at the time of inspection: Ms Isabel Neves, Acting Manager	**Number of registered places:** 98 This number includes: • a maximum of 28 patients in categories NH-I, NH-PH, NH-PH(E), NH-TI to be accommodated in the general nursing unit, and • a maximum of 70 patients in category NH-DE to be accommodated in the dementia unit. The home is also approved to provide care on a day basis for four patients in the general nursing unit and one patient in the dementia unit.
Categories of care: Nursing Home (NH) I – old age not falling within any other category DE – dementia 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:** 62
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 98 patients. There are four units in the home over the first and second floors. Patients in each unit have access to individual bedrooms, communal lounges, dining rooms and enclosed outside spaces.	

2.0 Inspection summary

An unannounced inspection took place on 8 October 2021 from 10:00am to 5:00pm. This inspection was conducted by two pharmacist inspectors and focused on medicines management.

The inspection also assessed progress with any areas for improvement identified since the last care and medicines management inspections.

Review of medicines management found that arrangements were in place to ensure staff were trained and competent to manage medicines. Care plans in relation to medicines were in place to direct staff. Improvements were needed in relation to the storage areas for medicines, completion of medicine administration records and medicines audit.

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. To complete the inspection 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 were reviewed.

4.0 What people told us about the service

The inspectors met with five nurses, 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 were warm and friendly and it was evident from their interactions 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. In order to reduce footfall throughout the home the views of patient's were not sought during this inspection.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered 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 last inspection?

Areas for improvement from the last inspection on 21 & 22 June 2021		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that, in accordance with NMC guidelines, contemporaneous records of wound care are maintained.	**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 43 **Stated:** First time	The registered person shall ensure that en-suites are decluttered and that equipment is stored in appropriate areas.	**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 30 **Stated:** First time	The registered person shall ensure that thickening agents are safely and securely stored and are not accessible to patients.	**Met**
	Action taken as confirmed during the inspection: Thickening agents were stored safely and securely in locked treatment rooms which were not accessible to patients.	

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 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 nurse had checked and signed the personal medication records when they were written and updated to provide a check 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.

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 nurses 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. 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. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. Records of administration were clearly recorded.

The reason for and outcome of administration were recorded on supplementary "when required" medicine administration records. One patient requiring regular daily administration of a "when required" medicine for distressed reactions was highlighted to the manager for ongoing review and assessment.

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.

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 for four patients was reviewed. A speech and language assessment report and care plan were in place for each patient. Records of prescribing and administration which included the recommended consistency level were maintained.

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 for one patient was reviewed. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Nurses on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route. Records of administration of the nutritional supplement and fluid intake were incomplete. The total fluid intake and start/stop times of the prescribed nutritional supplement were not documented on daily fluid intake charts. This is necessary to ensure the patients' recommended daily fluid and nutritional supplement intake is achieved and to facilitate monitoring and review. An area for improvement was identified.

The management of warfarin was reviewed. Care plans were in place to direct staff. Warfarin dosage regimes were communicated to the home via e-mail from the GP surgery. Staff were reminded that communicated warfarin dosage regimes should consistently be transcribed by two members of staff to ensure accuracy. The good practice of separate warfarin administration records including running stock balances was acknowledged.

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. Nurses 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. However, storage areas were found to be cluttered and untidy. Treatment room floors were not clean and receptacles used to administer medicines to patients had been left in sinks on the day of inspection. Trolleys used to store patients' medicines required cleaning to ensure compliance with infection prevention and control (IPC). An area for improvement was identified.

Review of the cold storage of medicines identified medicine refrigerator temperatures including the daily minimum and maximum temperature were recorded on a daily basis. Nurses were reminded that the thermometer should be reset each day after the maximum, minimum and current temperatures have been recorded. Various medicines including creams and injections which do not require cold storage were observed to be stored in the medicines refrigerators on the day of inspection. This was highlighted to the manager for action to ensure medicines are stored according to the manufacturer's recommendations.

Satisfactory arrangements for the disposal of medicines were in place. Records of the disposal of medicines were maintained and available for inspection.

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. However, a number of missed signatures were brought to the attention of the manager for ongoing close monitoring. Nurses recorded the administration of warfarin on both the MARs and supplementary administration records. The supplementary records were not referenced clearly on the MARs and nurses were not always maintaining both records. The importance of maintaining full and contemporaneous records of the administration of medicines was discussed with the manager. The records of administration were filed once completed; however they were not easily retrievable for review or inspection. An area for improvement was identified in relation to medicine administration records as stated in Section 5.2.1.

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 are recorded in a controlled drug record book. Records of receipt, administration and disposal had been maintained to the required standard. However, on one occasion when a subcutaneous Schedule 2 controlled drug had been administered to a patient nursing staff had recorded the amount administered from the ampoule but did not document the quantity discarded. This was an isolated incident and nursing staff were reminded to consistently document the amount of controlled drug discarded.

Written authorisation from the prescriber was in place when medicines were administered covertly to patients. The care plan reviewed did not detail how each medicine should be administered. This was discussed with the manager who agreed to update the care plan following the inspection.

The audits completed during the inspection identified the majority of medicines had been administered as prescribed. However, discrepancies were identified for three antibiotic medicines indicating they had not been administered as prescribed. Nurses maintained running stock balances following each administration of liquid medicines. A number of these balances did not correspond to the quantity of the liquid medicine in stock on the day of inspection indicating that the medicines had not been administered as prescribed and that the audit process was ineffective.

The registered person should implement a robust audit system which covers all aspects of the management and administration of medicines. 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.

The management of medicines for two patients who had a recent hospital stay and were discharged back to this home was reviewed. 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. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

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 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 learning shared with staff in order to prevent a recurrence.

As discussed in section 5.2.3 the findings of this inspection indicate the current audit system is not robust and is not effective at identifying medicine related incidents. The need for a robust audit system which incorporates all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.

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. Policies and procedures should be up to date and readily available for staff.

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.

Records of staff training in relation to medicines management were available for inspection.

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 in relation to medicines management.

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 medicine storage areas, completion of medicine administration records and medicines audit.

Whilst we identified areas for improvement, we can conclude that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed by their GP.

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 were 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	3*	2*

* the total number of areas for improvement includes two under the standards which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Isabel Neves, 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:** Ongoing from the date of inspection (8 October 2021)	The registered person shall ensure that complete and contemporaneous records of the administration of medicines are maintained, including medicines and nutritional supplements administered via the enteral route. Ref: 5.2.1 & 5.2.3
	Response by registered person detailing the actions taken: Importance of maintaining full and contemporaneous records of the administration of medicines was addressed in detailed and in-depth training for registered nurses. Audit systems reviewed to oversee same. Filing system implemented in order to easily retrieve any records for auditing/ inspection. Records of administration of medicines and nutritional supplements administered via enteral route are now kept in Kardex and digitally in EpicCare Electronic record system.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Ongoing from the date of inspection (8 October 2021)	The registered person shall ensure that medicine storage areas are de-cluttered and maintained in line with infection prevention and control (IPC) measures. Ref: 5.2.2
	Response by registered person detailing the actions taken: New equipment being provided by pharmacy (new fridges and new medication trolleys). Cleaning schedules for Domestic staff reviewed and same are checked during weekly Infection Control Audits. Cleaning schedules allocated to nurses including weekly deep clean of medicine trolley. Pharmacy providing single use receptacles to use to administer medicines.
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** Ongoing from the date of inspection (8 October 2021)	The registered person shall ensure a robust audit system which covers all aspects of medicines management and administration is implemented to ensure safe systems are in place. Ref: 5.2.3 &5.2.5
	Response by registered person detailing the actions taken: Audit systems reviewed and new audits implemented. Nurses on duty to complete daily medicine audits in order for all residents' medicines to be audited on a monthly basis and allocated nurses to ensure same to comply with nursing home standards. Management audit implemented to oversee audits and ensure

	all actions are reviewed and completed and to close the “Audit Loop”. New Labels system, to prompt nurses to document dates of opening, being implemented to facilitate audits. Medication link nurse identified to improve governance and medication management.

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 28 June 2021	The registered person shall ensure that, in accordance with NMC guidelines, contemporaneous records of wound care are maintained.
	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 43 **Stated:** First time **To be completed by:** 6 July 2021	The registered person shall ensure that en-suites are decluttered and that equipment is stored in appropriate areas.
	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

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