The Regulation and Quality Improvement Authority

Inspection Report

27 August 2021

Phoenix Clinic & Resource Centre

Type of service: Nursing Home
Address: 1 Lansdowne Road, Newtownards, BT23 4NT
Telephone number: 028 9182 2111

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: Phoenix Healthcare (N.I.) Ltd **Responsible Individual:** Mr Iain McCartney	**Registered Manager:** Ms Karen Lynda Edwards **Date registered:** 7 November 2012
Person in charge at the time of inspection: Ms Gemma McClean, Nurse-in-charge	**Number of registered places:** 36
Categories of care: Nursing (NH): PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 28
Brief description of the accommodation/how the service operates: This is a nursing home registered to provide nursing care for up to 36 patients.	

2.0 Inspection summary

An unannounced inspection took place on 27 August 2021 from 11.00am to 3.10pm. The inspection was carried out by a pharmacist inspector.

This inspection focused on medicines management within the home.

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.

During our inspection we:

- 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

We met with two nurses. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed. We discussed the inspection findings with the manager via telephone call on 1 September 2021.

Nurses were warm and friendly and it was evident from their interactions that they knew the patients well. Patients were observed to be relaxing in the lounges.

Nurses expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after patients and meet their needs. They spoke highly of the support given by management.

In order to reduce footfall throughout the home, we did not meet with any patients. Feedback methods included a staff poster and paper questionnaires which were provided to the staff 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 responses had been received.

5.0 The inspection

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

The last inspection of the nursing home was undertaken on 22 December 2020 by a care inspector; no areas for improvement were identified.

No areas for improvement were identified at the last medicines management inspection on 9 November 2017.

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, for example, at medication reviews and hospital appointments.

It was acknowledged the majority of 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 ensure accuracy. However, a number of recent changes to prescribed medicines had not been recorded on the personal medication records. This was discussed with the nurses on duty; they were knowledgeable about the changes and the medicines had been administered correctly. However, if personal medication records are not up to date this could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. 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, 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 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.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. 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 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 in the daily progress notes on most occasions. Nurses were reminded that this should be recorded on all occasions.

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. One care plan required to be updated and this was actioned at 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 was reviewed for four patients. Speech and language assessment reports and care plans were in place. 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. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route. The management of medicines and nutrition via the enteral route was reviewed for one patient. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. It was agreed that the daily fluid intake charts would be totalled each day to ensure that appropriate action is taken if the recommended fluid intake is not achieved.

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. They were tidy and organised so that medicines belonging to each patient could be easily located.

A review of the daily records for the refrigerator temperature indicated that that the thermometer was not being reset each day and that the maximum temperature was consistently above 8^{o}C. Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to ensure their viability. The registered person must ensure that staff receive guidance on how to accurately monitor the refrigerator temperature and reset the thermometer each day. Corrective action must be taken if temperatures outside the required range are observed. An area for improvement was identified. It was agreed that the room temperature would be monitored in the rooms where nutritional supplements are stored.

A number of medicines including Glucogel, eye preparations and in-use insulin pens were removed from the refrigerator at the inspection. Nurses were reminded that these medicines should be stored at room temperature, in accordance with the manufacturers' instructions. Nurses were also reminded that cefalexin suspension must be discarded at expiry and that lidocaine pouches must be resealed. This was actioned at the inspection.

The disposal arrangements for medicines were reviewed. Discontinued medicines were returned to a community pharmacy who hold a waste management licence and records were maintained. Nurses advised that controlled drugs in Schedule 2, 3 and 4, Part (1) were not denatured and rendered irretrievable prior to disposal. An area for improvement was identified.

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, when medicines are administered to a patient. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the nurses on duty. Accurate medicine administration records were not maintained for medicines administered from weekly compliance aids (See Section 5.2.4).

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. Records of receipt and administration and disposal of controlled drugs had been maintained to the required standard.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The audits completed at the inspection indicated that medicines were administered as prescribed. However, as shortfalls were identified in relation to several areas of medicines management detailed in this report, the audit system should be further developed to include all aspects of medicines management. 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 patients who had recently been admitted to the home for long term and short term care were reviewed. The patients' own medicines had been received into the home and were administered in accordance with the directions on the labels.

The personal medication records were written by one nurse from information provided by family and the medication supplied. An accurate list of currently prescribed medicines had not been obtained from the GP or community pharmacy and hence nurses could not be sure that the patients were administered all of their prescribed medicines or a discontinued medicine/incorrect dose. Hand-written medication administration records had not been verified and signed by two nurses to ensure accuracy. When medicines were administered from compliance aids, nurses had not signed for the administration of each medicine. Records for the prescribing and administration of a health supplement supplied by family were not maintained.

The management of medicines on admission must be reviewed to ensure that:

- an accurate list of currently prescribed medicines is received from the hospital or GP to ensure that medicines are administered in accordance with the most recent directions
- personal medication records are verified and signed by two nurses to ensure accuracy of transcription
- hand-written medication administration records are verified and signed by two nurses to ensure accuracy of transcription
- accurate records of administration are maintained
- the administration of non-prescribed medicines is recorded e.g. non-prescribed health supplement

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 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.

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.

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.

The manager advised that staff received a structured induction which included medicines management when this forms part of their role. Competency was assessed following induction and annually thereafter.

The manager advised that the outcomes of the inspection would be discussed with all staff in order to drive the necessary improvements.

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 the management of medicines on admission, record keeping, the storage of medicines, the disposal of controlled drugs and the auditing system.

Although areas for improvement were identified, the audits completed at the inspection indicated that medicines were administered 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	5	0

Areas for improvement and details of the Quality Improvement Plan were discussed with nurses on duty at the inspection and with the registered manager, Ms Karen Edwards, via telephone call on 1 September 2021, 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:** From the date of the inspection	The registered person shall ensure that personal medication records are up to date. Ref: 5.2.1
	Response by registered person detailing the actions taken: AMARRS AND KARDEX AUDITS ARE COMPLETED REGULARLY TO ENSURE PERSONAL MEDICATION RECORDS ARE UP TO DATE
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that the refrigerator temperature is maintained between 2^{o}C and 8^{o}C, the thermometer is reset each day and corrective action is taken if temperatures outside the required range are observed. Ref: 5.2.2
	Response by registered person detailing the actions taken: THE FRIDGE IS NOW RESET DAILY. NEW CONTROL PANEL HAS BEEN FITTED TO FRIDGE AND TEMPERATURE RANGES ARE CORRECT
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that controlled drugs in Schedules 2, 3 and 4, Part 1 are denatured and rendered irretrievable prior to disposal. Ref. 5.2.2
	Response by registered person detailing the actions taken: CONTROLLED DRUGS ARE NOW DENATURED ON THE PREMISES PRIOR TO DISPOSAL
Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall implement a robust auditing system which covers all aspects of the management of medicines, including the areas of improvement identified at this inspection. Ref: 5.2.3
	Response by registered person detailing the actions taken: A MORE ROBUST AUDITING SYSTEM IS NOW IN PLACE AND COMPLETED WEEKLY BY NURSE MANAGER
Area for improvement 5 **Ref:** Regulation 13 (4)	The registered person shall review and revise the management of medicines on admission as detailed in the report. Ref: 5.2.3 & 5.2.4

Stated: First time **To be completed by:** From the date of inspection	**Response by registered person detailing the actions taken**: ALL NEW ADMISSIONS FROM THE COMMUNITY HAVE A PRESCRIPTION FROM THEIR GP FOR THEIR MEDICATION

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