

Inspection Report

20 April 2021



Pond Park Care Home

Type of service: Nursing Home
Address: Pond Park Care Home, Lisburn BT28 3SF
Telephone number: 028 9267 2911

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Healthcare Ireland (Belfast) Limited Responsible Individual(s): Ms Amanda Celine Mitchell	Registered Manager: Mrs Florentina Moca (Acting)
Person in charge at the time of inspection: Ms Julie McCall, Manager	Number of registered places: 58
Categories of care: Nursing Home (NH): DE – dementia 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: 51
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide nursing care for up to 58 patients.	

2.0 Inspection summary

An unannounced inspection took place on 20 April 2021 from 10.00 am to 2.45 pm. The inspection was carried out by two pharmacist inspectors.

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to the management of medicines.

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 care 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 we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

To complete the inspection we reviewed: 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.

During our inspection the inspectors:

- 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 the manager, deputy manager, clinical lead nurse, nurse and one care assistant. 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. Patients were observed to be relaxing in lounges/bedrooms throughout the home.

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. They spoke highly of the support given from management in the home. Feedback received from one member of staff was discussed with the manager (via telephone) for escalation to the senior team.

In order to reduce the footfall throughout the home, the inspectors did not meet with any patients during the inspection. 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.

One relative completed and returned a questionnaire. Their responses indicated that they were "very satisfied" with all aspects of the care provided.

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 8 December 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 13 (7) Stated: First time	<p>The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.</p> <p>This is with specific reference to:</p> <ul style="list-style-type: none"> the cleaning of undersides of toilet paper dispensers and shower chairs the repair and/or replacement of identified shower drains and commodes. <p>A more robust system should be in place to ensure compliance with best practice on infection prevention and control.</p>	Carried forward to the next inspection
	<p>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.</p>	

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		Validation of compliance summary
Area for improvement 1 Ref: Standard 5 Stated: First time	The registered person shall ensure that all staff have completed training in relation to the Mental Capacity Act (NI) 2016 and Deprivation of Liberty Safeguards (DoLS), to a level appropriate to their role and responsibilities.	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 6 Stated: First time	The registered person shall ensure that net pants are only ever provided for individual patient use and any unlabelled items of clothing are identified and labelled or disposed of to eliminate the potential for communal use.	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 outcome

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the 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 e.g. medication reviews, 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 double 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 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.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed. 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 records of administration were maintained. However, care plans directing the use of these medicines were not available for all relevant patients and, the reason for and outcome of administration were not routinely recorded. An area for improvement was identified.

Care plans for the management of pain were available. The audits completed at the inspection indicated that pain relief was administered as prescribed. Staff advised that they were familiar with how each patient expressed their pain and that additional 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 was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Patients who live in care homes and have been assessed as lacking capacity can be administered medicines covertly if a management plan is agreed following a best interests meeting. The covert administration of medicines should only be used in exceptional circumstances when such a means is deemed necessary. Medicines were administered covertly to a small number of patients. For one patient it was noted that a care plan was not available in their notes. The manager agreed to address this immediately following the inspection.

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 the majority of medicines were available for administration as prescribed. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner. However, it was noted that two doses of one medicine and five doses of a second medicine had been omitted as they were out of stock. This was followed up at the inspection and assurances were provided that the medicines would be received on the afternoon of the inspection. Nurses must ensure that medicines are available for administration as prescribed. Any omissions should be referred to the prescriber for guidance. An area for improvement was identified.

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. The treatment room temperature was above 25°C in the Wallace suite and the room needed to be decluttered. It was agreed that the room temperature would continue to be closely monitored and that corrective action would be taken if necessary. The manager said that the room would be decluttered following the inspection.

Satisfactory systems 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. They had been completed in a satisfactory manner.

The storage and administration of insulin was reviewed. In-use insulin pens were stored at room temperature. However, not all pens were individually labelled and the date of opening had not been recorded. This is necessary to facilitate audit and disposal at expiry. In addition, the dosage directions had been abbreviated which increases the risk of an incorrect dose being administered. 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 were recorded in a controlled drug record book. Nurses were reminded that the balance of controlled drugs should be brought to zero in the controlled drug record book when controlled drugs are denatured/transferred out of the home.

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 the majority of medicines so that they could be easily audited. This is good practice.

The medicine cups used to administer medicines to patients were labelled as single use. Therefore, they should be discarded after each use. It was noted that some of the medicine cups were washed after use and then reused. This matter was discussed with the manager who gave an assurance that the necessary arrangements would be made to ensure that this practice is stopped.

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 on admission was reviewed. Medicines had been confirmed in writing with the prescriber (hospital discharge letters/ GP printouts). The patients' personal medication records had been checked and verified by a second nurse. For two patients the quantity of medicines received into the home had not been accurately recorded which meant that there was not a clear audit trail to confirm that the medicines had been administered as prescribed. 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 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.

Management and staff were familiar with the type of incidents that should be reported.

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.

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.

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 stock management, records of medicines received into the home and the management of distressed reactions and insulin.

Although we identified areas for improvement, we can conclude that overall, medicines were being administered to patients 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 where action is required to ensure compliance with the Nursing Home Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (2015).

	Regulations	Standards
Total number of Areas for Improvement	3*	4*

* The total number of areas for improvement includes one under the regulations and two under the standards that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Julie McCall, 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	
<p>Area for improvement 1</p> <p>Ref: Regulation 13 (7)</p> <p>Stated: First time</p> <p>To be completed by: Immediate and ongoing from the date of inspection</p>	<p>The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.</p> <p>This is with specific reference to:</p> <ul style="list-style-type: none"> • the cleaning of undersides of toilet paper dispensers and shower chairs • the repair and/or replacement of identified shower drains and commodes <p>A more robust system should be in place to ensure compliance with best practice on infection prevention and control.</p>
	<p>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.</p> <p>Ref 5.1</p>
<p>Area for improvement 2</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: From the date of the inspection</p>	<p>The registered person shall ensure that medicines are available for administration as prescribed. Any omissions must be referred to the prescriber for guidance.</p> <p>Ref 5.2.2</p>
	<p>Response by registered person detailing the actions taken: registered person will ensure that only the deputy manager and clinical leads over see the ordering of monthly medications to ensure that the correct amount is received for each resident.</p> <p>any omissions will be referred to the prescriber and home manager in a timely manner.</p>
<p>Area for improvement 3</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: From the date of the inspection</p>	<p>The registered person shall ensure that records of medicines received into the home are accurately maintained in order to facilitate a clear audit trail to provide evidence that medicines are being administered as prescribed.</p> <p>Ref 5.2.4</p>
	<p>Response by registered person detailing the actions taken: The registered person and Deputy manager will oversee supervisions with all trained staff. This will include the process of recording medications into the home to maintain a good audit</p>

	trail. The registered person will continue to audit this within their monthly audit
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Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
<p>Area for improvement 1</p> <p>Ref: Standard 5</p> <p>Stated: First time</p> <p>To be completed by: 29 January 2021</p>	<p>The registered person shall ensure that all staff have completed training in relation to the Mental Capacity Act (NI) 2016 and Deprivation of Liberty Safeguards (DoLS), to a level appropriate to their role and responsibilities.</p> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.</p> <p>Ref 5.1</p>
<p>Area for improvement 2</p> <p>Ref: Standard 6</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect</p>	<p>The registered person shall ensure that net pants are only ever provided for individual patient use and any unlabelled items of clothing are identified and labelled or disposed of to eliminate the potential for communal use.</p> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.</p> <p>Ref. 5.1</p>
<p>Area for improvement 3</p> <p>Ref: Standard 18</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect</p>	<p>The registered person shall review the management of medicines for distressed reactions to ensure that:</p> <ul style="list-style-type: none"> • detailed care plans are in place • the reason for and outcome of each administration are recorded <p>Ref. 5.2.1</p> <p>Response by registered person detailing the actions taken: All residents that require medications for distressed reactions shall be reviewed to ensure that a detailed care plan is in place.</p> <p>All trained staff will under go a supervision with the registered person /Deputy manager this will include the importance of documenting on progress notes and care plans the reasoning for administration of medications for distressed reactions. this will enable staff to identify trends or triggers.</p>

<p>Area for improvement 4</p> <p>Ref: Standard 28</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect</p>	<p>The registered person shall review the management of insulin to ensure that:</p> <ul style="list-style-type: none"> • each pen is labelled to denote ownership • the date of opening is recorded to facilitate audit and disposal at expiry • dosage directions are not abbreviated
	<p>Response by registered person detailing the actions taken: all insulin pens have since been checked by the registered person, all labelled correctly, date of opening evident on each pen and no abbreviated directions noted.</p> <p>the registered person has implemented checking and monitoring of insulin pens onto the managers monthly medication audit to ensure compliance continues.</p>

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