The Regulation and Quality Improvement Authority

Inspection Report

24 April 2023

Strangford Court

Type of service: Nursing Home
Address: 26 Strangford Road, Downpatrick, BT30 6SL
Telephone number: 028 4461 2481

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: Ann's Care Homes **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Ms Claire Quail **Date registered:** 10 March 2011
Person in charge at the time of inspection: Ms Claire Quail	**Number of registered places:** 36
Categories of care: Nursing (NH): DE – dementia LD – learning disability LD(E) – learning disability – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 34
Brief description of the accommodation/how the service operates: Strangford Court is a registered nursing home which provides nursing care for up to 22 patients with dementia in Millar Suite and up to 14 patients who have a learning disability in Oakland Suite. All bedrooms and amenities are located on the ground floor. Patients have access to communal lounges/dining rooms and an enclosed garden/patio area.	

2.0 Inspection summary

An unannounced inspection took place on 24 April 2023, from 10.30am to 2.40pm. The inspection 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 area for improvement identified at the last care inspection will be followed up at the next inspection.

Robust governance systems were in place to ensure that medicines were managed safely and administered as prescribed. Medicine records and medicine related care plans were well maintained. Medicines were stored securely. Staff had received training and been deemed competent to manage and administer medicines. No new areas for improvement were identified.

RQIA would like to thank the manager 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, the deputy manager 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 expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

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 20 January 2023		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 39 **Stated:** First time	The registered person shall ensure that staff orientation and induction records are meaningfully reviewed, signed and dated when this has been achieved.	**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.	

5.2.1 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 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.

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.

The management of distressed reactions, pain, insulin, thickening agents and antibiotics was reviewed. Care plans contained sufficient detail to direct the required care. Records of prescribing and administration were well maintained. The audits completed at the inspection indicated that these medicines were administered as prescribed.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine 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. A review of the daily records indicated that these temperatures were maintained. However, the consistent recordings for the maximum and minimum temperatures indicated that the thermometer was not reset each day. Guidance on resetting the thermometer was provided. The manager was also reminded that appropriate corrective action must be taken if the temperature of the treatment room exceeds 25^{o}C.

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.

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.

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. Management and staff audited medicine administration on a regular basis within the home. In addition, 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.

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 in place to manage medicines for patients new to the home or returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the GP and community pharmacist. The medicine records had been accurately completed. There was evidence that nurses 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 nurses can learn from the incident.

The audit system in place helps nurses to identify medicine related incidents. Management and nurses 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 in order to prevent a recurrence.

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.

Nurses in the home had received a structured induction which included medicines management. Update training was provided annually. Competency assessments were completed annually or more frequently if a need was identified.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	1*

* One area for improvement has been carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Ms Claire Quail, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for Improvement 1 **Ref:** Standard 39 **Stated:** First time **To be completed by:** With immediate effect (20 January 2023)	The registered person shall ensure that staff orientation and induction records are meaningfully reviewed, signed and dated when this has been achieved. **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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