The Regulation and Quality Improvement Authority

Inspection Report

7 July 2021

Scrabo Isles

Type of service: Nursing Home
Address: 61 Manse Road, Newtownards, BT23 4TP
Telephone number: 028 9181 2231

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: Tona Enterprises Ltd **Responsible Individual:** Mr Robert Maxwell Duncan	**Registered Manager:** Ms Annalyn Depayso **Date registered:** 27 March 2009
Person in charge at the time of inspection: Ms Annalyn Depayso	**Number of registered places:** 35
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:** 31
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for up to 35 patients.	

2.0 Inspection summary

An unannounced inspection took place on 7 July 2021 between 10.40am and 2.30pm. 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

The inspector met with one nurse 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. Patients were observed to be relaxing in lounges throughout the home.

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, the inspector did not meet with any patients. 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 seven responses were returned. All responses indicated that relatives/patients were “very satisfied” with the care provided. Comments made included:

“The care is very good and they always try their best.”

“I feel I am surrounded by beautiful people and lovely things.”

“The staff are very kind and understanding. I really like it here.”

“I am very happy and content with the care that is provided.”

5.0 The inspection

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

No areas for improvement were identified at the last medicines management inspection (25 July 2017) or at the last care inspection (11 September 2020).

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.

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 are written to ensure that they were accurate. The manager was reminded that any updates on the personal medication records should also be verified and signed by two nurses and that obsolete personal medication records should be cancelled and archived. This is necessary to ensure that staff refer to the up to date personal medication records only.

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 for two patients. Staff knew how to recognise signs, symptoms and triggers which may cause a change in each 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. The medicines had not been administered recently. The manager and nurse advised that when administered the reason and outcome is recorded.

The management of pain was reviewed for two patients. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place and the audits carried out at the inspection indicated that the medicines had been 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 four patients. Speech and language assessment reports and care plans were in place. Care assistants maintained records of administration. However, records of prescribing and administration were not maintained on the personal medication records and medication administration records. An area for improvement was identified.

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 door to the treatment room was observed to be securely locked to prevent any unauthorised access. However, the medicines refrigerator and medicine cupboards were not locked. The manager advised that only nurses had access to the treatment room. Storage was tidy and organised so that medicines belonging to each patient could be easily located. A number of out of date medicines were observed. These medicines were not in current use and were removed for disposal. The manager agreed to review the storage arrangements for inhaled medicines and eye drops to ensure that they meet infection prevention and control standards.

A review of the daily medicines refrigerator temperature records showed that the minimum/ maximum temperatures were consistently 2°C and 8°C which indicates that the thermometer was not reset each day after the temperatures were checked. The thermometer was reset at the inspection and appropriate temperatures were observed. It was agreed that nurses would receive supervision on monitoring the refrigerator temperature and that this would be monitored through the audit process.

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). A sample of these records was reviewed. For one part of the home the nurse had signed the MARs until the end of the day i.e. records for the administration of the lunchtime and evening medicines had been signed during the morning medication round. This practice is unacceptable. Records of administration must be signed at the time of administration. For a small number of medicines, records of administration did not correlate with the prescribed directions , for example, pregabalin and a calcium supplement were prescribed to be administered twice daily but the records of administration indicated that they were administered once daily. This was discussed with the manager who advised that nurses may have copied previous entries rather than carefully completing the records. 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 are recorded in a controlled drug record book. These had been maintained to the required standard.

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.

There had been no recent admissions to the home. The admission process for patients new to the home or returning to the home after receiving hospital care was discussed. The manager advised that robust arrangements were in place to ensure that the home was provided with an accurate list of medicines from the hospital and this was shared with the patient’s GP and the community pharmacist.

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.

There have been no medicine related incidents reported to RQIA since the last inspection. The findings of this inspection indicate that the current auditing system is not robust and hence incidents may not be identified. The audits completed at the inspection indicated that the

majority of medicines had been administered as prescribed. However, one discrepancy was highlighted to the manager for investigation. An incident report detailing the outcome of the investigation and action taken to prevent a recurrence was submitted to RQIA on 9 July 2021. A robust auditing system which includes all aspects of the management of medicines, including those identified at this inspection should be developed and implemented. An area for improvement was identified.

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 use.

There had been no new nurses recruited since 2016. Update training on medicines management and competency assessments were completed annually. The manager was currently reviewing nurse competencies. It was agreed that the findings of this inspection would be discussed with all nurses for ongoing improvement.

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 thickening agents, records for the administration of medicines and implementing a robust audit system. Although areas for improvement were identified, RQIA is assured that, with the exception of a small number of medicines, the patients were administered their medicines 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	2	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Annalyn Depayso, Registered 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:** From the date of the inspection	The registered person shall ensure that accurate records for the prescribing and administration of thickening agents are maintained. Ref: 5.2.1
	Response by registered person detailing the actions taken: All thickening agents including SALT recommendations are clearly written in Medication Administration Records and on Personal Administration Records.
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that accurate and contemporaneous medication administration records are maintained. Ref: 5.2.3
	Response by registered person detailing the actions taken: All nurses were reminded to maintain accurate and contemporaneous medication administration records . This was thoroughly discussed during Nurses meeting on 10 July 2021. Two nurses will check and verify all labels of medications when new supplies arrive and when receiving newly prescribed medications and compare with what was written on Personal Medication Records and on Medications Administration Record Sheets to ensure they reflect the most recent prescription. Any discrepancies will be verified with the prescriber.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall develop and implement a robust audit tool which covers all aspects of the management of medicines. Ref: 5.2.5
	Response by registered person detailing the actions taken: New audit tool was designed and being used randomly. Random checks on going.

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