The Regulation and Quality Improvement Authority

Inspection Report

23 November 2021

Seaview House

Type of service: Nursing Home
Address: 276 Seacliff Road, Ballyholme, Bangor, BT20 5HS
Telephone number: 028 9146 0833

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: Kingsfield Enterprises Limited **Responsible Individual:** Mrs Valerie Elizabeth Atcheson	**Registered Manager:** Mrs Ruth Magowan **Date registered:** 25 October 2018
Person in charge at the time of inspection: Mrs Ruth Magowan	**Number of registered places:** 22
Categories of care: Nursing Home (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:** 20
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 22 patients. Patients' bedrooms are located over three floors. Patients have access to communal lounges, a dining room and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 23 November 2021 from 9.30am to 3.00pm. The inspection was conducted by a care inspector and pharmacist inspector.

The findings of the last medicines management inspection on 30 September 2021 indicated that robust arrangements were not in place for all aspects of medicines management. Areas for improvement were identified in relation to the safe and secure storage of medicines, the standard of maintenance of medicine related records, the arrangements for the auditing of medicines and staff training and competency assessments.

These findings were discussed during a serious concerns meeting on 7 October 2021 with Mrs Valerie Atcheson, Responsible Individual and Mrs Ruth Magowan, Registered Manager. Following this meeting, RQIA decided that a period of time would be given to implement the necessary improvements and that this follow up inspection would be undertaken to determine if the necessary improvements had been implemented and sustained.

Therefore the purpose of this inspection was to determine the progress made in addressing the issues raised at the inspection on 30 September 2021. This inspection also sought to address compliance with the areas for improvement identified at the last care inspection on 29 July 2021.

Significant improvements in the management of medicines were observed during this inspection. The progress made was acknowledged. There were robust arrangements for auditing medicines and medicine related records were maintained to a satisfactory standard. Arrangements were in place to ensure that staff were trained and competent in medicines management. Medicines were stored safely and securely. The manager was reminded that the improvements must be sustained.

It was positive to note that as a result of this inspection no new areas for improvement were identified. Areas for improvement which were met, partially met or which were carried forward for review at the next inspection are discussed in the main body of the report and Quality Improvement Plan.

Patients said that they felt comfortable and well looked after in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

The findings of this report will provide the management team with the necessary information to improve staff practice and the patients' experience.

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, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines were reviewed. Additionally, a sample of staff duty rotas, governance audits, wound care records, records of accidents/incidents and care records were reviewed.

The inspectors also 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; and reviewed documents to confirm that appropriate records were kept.

4.0 What people told us about the service

The inspectors met with nurses, care staff and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Patients said that there were enough staff to help them and they felt well looked after. Relatives said that they were satisfied with the care provided, communication was good and staff were helpful and friendly.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well. Staff advised that they had worked hard to improve the management of medicines and that the changes implemented had been effective and were sustainable.

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.

Following the inspection one completed questionnaire was returned to RQIA. The relative indicated they were very dissatisfied across all domains but no additional comments were made and their contact details were not provided for follow up. This was brought to the attention of the manager for information and action if required.

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 30 September 2021		
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time	The registered person shall ensure that all medication in the home is safely and securely stored.	**Met**
	Action taken as confirmed during the inspection: Medication in the home was safely and securely stored. **See Section 5.2.1**	
Area for improvement 2 **Ref:** Regulation 27 (4) (c) **Stated:** First time	The registered person shall ensure that all fire exits in the home are unobstructed at all times.	**Met**
	Action taken as confirmed during the inspection: Fire exits in the home were seen to be unobstructed. **See Section 5.2.2**	

Area for improvement 3 **Ref:** Regulation 10 (1) **Stated:** First time	The registered person shall ensure that there is a robust governance system in place to regularly monitor the care and services provided, including, but not limited to, care records, accidents/incidents and the environment. The audits completed should include an action plan, timescale and identify the person responsible for completing where required.	**Carried forward to the next inspection**
	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. **See Section 5.2.3**	
Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that fully complete and accurate personal medication records are maintained and obsolete records are cancelled and archived.	**Met**
	Action taken as confirmed during the inspection: Satisfactory systems were in place for the management of personal medication records. **See Section 5.2.4**	
Area for improvement 5 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that complete and contemporaneous records of the administration of medicines are maintained.	**Met**
	Action taken as confirmed during the inspection: Complete and contemporaneous records of the administration of medicines were maintained. **See Section 5.2.5**	
Area for improvement 6 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall investigate the findings regarding the identified medicines, report these to the prescriber and provide details of the findings and action taken.	**Met**
	Action taken as confirmed during the inspection: A written report of the investigation findings and action taken regarding the identified	

	medicines was received by RQIA on 7 December 2021. **See Section 5.2.6**	
Area for improvement 7 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that a robust system of audit which covers all aspects of medicines management is implemented to ensure safe systems are in place.	**Met**
	Action taken as confirmed during the inspection: There was evidence that a robust auditing system had been developed and implemented and was effective in identifying areas for improvement. **See Section 5.2.7**	
Area for improvement 8 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that RQIA are notified of any incident that adversely affects the health or wellbeing of any patient.	**Carried forward to the next inspection**
	Action required to ensure compliance with this regulation was not fully reviewed as part of this inspection and this is carried forward to the next inspection. **See Section 5.2.8**	
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 46.2 & 46.12 **Stated:** Second time	The registered person shall ensure that audits are completed to assure compliance with best practice regarding use of PPE.	**Met**
	Action taken as confirmed during the inspection: Review of records evidenced that audits regarding the use of PPE were regularly completed. **See Section 5.2.9**	

Area for improvement 2 **Ref**: Standard 4.9 **Stated:** Second time	The registered person shall ensure that up to date wound care records are maintained and that these contain an evaluation of the care provided. Wound care audits should also be completed on a regular basis in order that any deficits in wound care recording can be identified and resolved in a timely manner.	**Partially met**
	Action taken as confirmed during the inspection: Review of records evidenced that a wound care audit had been introduced. However, deficits were identified in wound care records. This area for improvement was partially met and will be stated for a third and final time. **See Section 5.2.10**	
Area for improvement 3 **Ref:** Standard 37 **Stated:** First time	The registered person shall ensure that accident/incident records are completed accurately and in full in line with legislative requirements and best practice guidance.	**Partially met**
	Action taken as confirmed during the inspection: Review of accident/incident records evidenced that follow up actions were not being recorded. This area for improvement was partially met and will be stated for a second time. **See Section 5.2.11**	
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that patients' care records are kept under regular review and updated as changes occur; evaluations of care records should be meaningful and individualised.	**Met**
	Action taken as confirmed during the inspection: Review of care records evidenced that regular review was undertaken. **See Section 5.2.12**	

Area for improvement 5 **Ref:** Standard 28 **Stated:** Second time	The registered person shall ensure that medications are administered in compliance with legislative requirements, professional standards and guidelines.	**Met**
	Action taken as confirmed during the inspection: Medicines were administered in compliance with legislative requirements, professional standards and guidelines. **See Section 5.2.13**	
Area for improvement 6 **Ref:** Standard 28 **Stated:** First time	The registered person shall ensure a comprehensive review of training and competency of all staff that have responsibility for managing medicines is undertaken.	**Met**
	Action taken as confirmed during the inspection: Medicines management training and competency assessments had been completed with all of the registered nurses. **See Section 5.2.14**	

5.2 Inspection findings

5.2.1 Safe and secure storage of medicines

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. Daily current, minimum and maximum medicine refrigerator temperatures were maintained to ensure medicines requiring cold storage were stored according to the manufacturer's instructions.

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

5.2.2 The environment and staffing arrangements

Fire exits throughout the home were observed to be accessible and free from any obstruction.

Observation of the home's environment evidenced that the home was warm, clean, tidy and fresh smelling throughout.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty. It was observed that there were enough staff in the home to respond to the needs of the patients in a timely way;

calls bells were answered promptly and patients were seen to receive the care they required at the right time. Staff said that they were satisfied with staffing levels and that teamwork was good.

5.2.3 Governance audits

There was evidence that progress had been made regarding the system of auditing in place to monitor the quality of care and other services provided to patients. Audits were completed regarding accidents/incidents and the environment. The manager said that completion of care record audits will be prioritised. This area for improvement will be carried forward for review at the next inspection.

5.2.4 Personal medication records

Following the last medicines management inspection a thorough review of all personal medication records had been undertaken by staff. The personal medication records reviewed at the inspection were accurate and up to date. Medication changes had been accurately recorded. The records had been verified and signed by two members of staff at the time of writing and at each update in order to ensure accuracy of transcribing.

5.2.5 Medicine administration records

A sample of the medicine administration records were reviewed. The records reviewed had been fully and accurately completed. It was evident from observation of the morning medicines round that these records were completed at the time of administration by nurses.

5.2.6 Investigation of the identified medicines

At the last medicines management inspection it was identified that an eye drop prescribed for an eye condition had been administered incorrectly for a period of 10 days. It could also not be determined if a second eye preparation had been administered as there was no record of administration. The registered manager was requested to urgently investigate this incident, determine the impact of this on the patient and update RQIA with the outcome.

Appropriate steps had been taken to ensure this incident was highlighted to the prescriber for immediate action and follow up. A written report of the investigation findings and action taken regarding the identified medicines was received by RQIA on 7 December 2021.
Audits conducted on the day of inspection identified the eye drops were being administered as prescribed.

5.2.7 Medicines audit

The findings of the last medicines management inspection identified the audit system in place for medicines management was not robust.

Improvements in the arrangements for auditing medicines in the home were observed. Management had reviewed the audit process and a range of audits were carried out. There was evidence that action plans had been put in place to address discrepancies identified. As part of this new process, nurses also complete a monthly medication audit and perform medication administration spot check audits. The date of opening was recorded on all medicines so that they could be easily audited. This is safe practice.

5.2.8 Notification of medication incidents

The audit system now in place helps staff to identify medicine related incidents. From discussions held with management and staff, it was evident they were familiar with the type of incidents that should be reported. In order to assess compliance with this area for improvement more time is required to evidence that any identified medicine incidents which can impact on the health and wellbeing of any patient are reported promptly to RQIA and other relevant stakeholders. This area for improvement is carried forward for review at the next inspection.

5.2.9 PPE audits

Review of records confirmed that regular audits to monitor staff use of PPE were completed. Staff were observed to use PPE in accordance with the regional guidance.

5.2.10 Wound care records

It was positive to note that a weekly wound care audit had been introduced to monitor progress with wound healing. However, review of a sample of three wound care records evidenced that in two records care plans had not been updated to reflect the current recommended wound dressing to be used or the frequency of dressing change. This area for improvement was partially met and will be stated for the third and final time. Review of wound progress records and discussion with nurses confirmed that wounds were redressed according to the current recommendations.

5.2.11 Accident and incident reports

Review of a sample of accident/incident reports evidenced that patient details were accurately recorded. However, the follow up section was not consistently being completed. This area for improvement was partially met and will be stated for the second time.

5.2.12 Care records

Review of a sample of patients' care records evidenced that these were regularly reviewed on at least a monthly basis. The evaluations were meaningful and individualised.

5.2.13 Medicines administration process

Observation of the morning medicines round evidenced that medicines were administered by nurses according to professional standards and guidelines. Nurses with responsibility for managing medicines informed the inspector that processes had improved following the last inspection and the medicines management training provided was now embedded into practice.

5.2.14 Staff training and competency assessment

To ensure that patients are well looked after and receive their medicines as prescribed, 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.

Update training on the management of medicines had been provided for all registered nurses. Competency assessments and nurse supervisions were completed following this training.

The findings of this inspection indicate that the training has been effective in driving 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 significant improvements in the management of medicines had been made. All medicine related areas for improvement identified at the last inspection have been addressed with the exception of one in relation to notifying RQIA of which is carried forward for review at the next inspection.

In relation to the last care inspection it was positive to note that three areas for improvement had been met and no new areas for improvement were identified. Based on the inspection findings one area for improvement relating to governance audits has been carried forward for review at the next inspection, one area relating to completion of accident/incident forms has been stated for a second time and one area relating to wound care records has been stated for a third and final time. Addressing the areas for improvement which have been carried forward or restated will further enhance the quality of care and services in the home.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	2*	2*

* The total number of areas for improvement includes one that has been stated for a second time, one which has been stated for a third and final time and two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Ruth Magowan, 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 10 (1) **Stated:** First time **To be completed by:** Ongoing from the date of the inspection (29 July 2021)	The registered person shall ensure that there is a robust governance system in place to regularly monitor the care and services provided, including, but not limited to, care records, accidents/incidents and the environment. The audits completed should include an action plan, timescale and identify the person responsible for completing where required.
	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. Ref: 5.2.3
Area for improvement 2 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (30 September 2021)	The registered person shall ensure that RQIA are notified of any incident that adversely affects the health or wellbeing of any patient.
	Action required to ensure compliance with this regulation was not fully reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.2.8
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4.9 **Stated:** Third and final time **To be completed by:** Ongoing from the date of the inspection	The registered person shall ensure that up to date wound care records are maintained and that these contain an evaluation of the care provided. Wound care audits should also be completed on a regular basis in order that any deficits in wound care recording can be identified and resolved in a timely manner. Ref: 5.2.10
	Response by registered person detailing the actions taken: The Home Manager will be responsible for ensuring wound records are up to date and reflective of patient status at all times. The Home Manager will complete the monthly audit

Area for improvement 2 **Ref:** Standard 37 **Stated:** Second time	The registered person shall ensure that accident/incident records are completed accurately and in full in line with legislative requirements and best practice guidance. Ref: 5.2.11
To be completed by: Ongoing from the date of the inspection	**Response by registered person detailing the actions taken:** The Home Manager holds responsibility for reviewing accident/incident reports at least weekly and ensuring they are followed up as necessary and all reporting streams have been informed. The Home Manager will complete a monthly audit.

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews