

Inspection Report

Name of Service: Seaview House

Provider: Kingsfield Enterprises Limited

Date of Inspection: 21 November 2024

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

1.0 Service information

Registered Provider:	Kingsfield Enterprises Limited
Responsible Individual:	Mrs Valerie Elizabeth Atcheson
Registered Manager:	Mrs Ruth Magowan
Service Profile: Seaview House is a nursing home registered to provide nursing care for up to 22 patients. Patient bedrooms are located over three floors. Patients have access to communal lounges, the dining room and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 21 November 2024, from 10.30am to 2.15pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely and staff were trained and competent to manage medicines and patients were administered the majority of their medicines as prescribed. However, improvements were necessary in relation to maintaining accurate personal medication records, handwritten medicine administration records and medicines management audit.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, patients were being administered their medicines as prescribed.

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 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 against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

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 said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each patient liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

3.3 Inspection findings

3.3.1 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.

Some personal medication records were not up to date with the most recent prescription. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. An area for improvement was identified.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

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.

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 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 distressed reactions, was reviewed. Directions for use were clearly recorded and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. These medicines were used infrequently but nurses advised that they would record the reason for and outcome of each administration.

The management of pain was discussed. 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 for the majority of patients and reviewed regularly. The manager provided an assurance that a care plan for one identified patient would be implemented immediately following 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 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.

3.3.2 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.

Records reviewed 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 medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage areas was monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

Satisfactory arrangements were in place for the safe disposal of medicines.

3.3.3 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.

A sample of the medicines administration records was reviewed. Most of the records were found to have been accurately completed. Some hand written medicines administration records did not include the full date and some had not been signed and verified as accurate by two nurses. 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 should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs. The manager was reminded that the two nurses signing for disposal of controlled drugs must always also record this in the controlled drug record book.

The audits completed by management and staff had not identified the issues identified at this inspection. The manager should implement a robust audit system which covers all aspects of the management of medicines including those identified at this inspection. Any shortfalls identified should be detailed in an action plan and addressed. An area for improvement was identified.

3.3.4 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 at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 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. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incident which had been reported to RQIA since the last inspection was discussed. There was evidence that the incident had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the manager for on-going vigilance.

3.3.6 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 they staff are competent in managing medicines and that they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent.

It was agreed that the findings of this inspection would be discussed with staff to facilitate ongoing improvement.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	1*	5*

* the total number of areas for improvement includes three 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 Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 9 (2) (c) Stated: First time To be completed by: With immediate effect (21 November 2024)	<p>The registered person shall ensure that a robust system is in place to monitor staff registration with NISCC. Records must be maintained to accurately reflect that staff are registered.</p> <hr/> <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> <p>Ref: 2.0</p>
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 29 Stated: First time To be completed by: With immediate effect (21 November 2024)	<p>The registered person shall ensure that accurate personal medication records are maintained and that they are signed and verified as accurate by two trained members of staff.</p> <p>Ref: 3.3.1</p> <hr/> <p>Response by registered person detailing the actions taken: Staff have received individual updates for medication policies and procedures. All staff are aware of the need for two signatories for all medication actions. This check is included in the monthly audit.</p>
Area for improvement 2 Ref: Standard 29 Stated: First time To be completed by: With immediate effect (21 November 2024)	<p>The registered person shall ensure that hand written medicines administration records contain the full date and are verified as accurate by two trained members of staff.</p> <p>Ref: 3.3.3</p> <hr/> <p>Response by registered person detailing the actions taken: As above.</p>

<p>Area for improvement 3</p> <p>Ref: Standard 28</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (21 December 2024)</p>	<p>The registered person shall implement a robust audit which covers all aspects of medicines management. Any shortfalls identified should be detailed in an action plan and addressed.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: A review of the medication audit resulted in a new audit being introduced and its outcome managed by the Home Manager and shared with the nursing team.</p>
<p>Area for improvement 4</p> <p>Ref: Standard 38</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (26 April 2024)</p>	<p>The registered person shall ensure that staff are recruited in accordance with relevant statutory employment legislation and mandatory requirements.</p> <p>This relates specifically to ensure that full employment history, reasons for leaving past employment and any gaps in employment records are explored and explanations recorded during the recruitment process.</p> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 5</p> <p>Ref: Standard 39</p> <p>Stated: First time</p> <p>To be completed by: 25 June 2024</p>	<p>The registered person shall ensure that all employed staff receive mandatory training in relation to the Mental Health Capacity Act – Deprivation of Liberty Safeguards (DoLS).</p> <p>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.</p> <p>Ref: 2.0</p>

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



The Regulation and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA



Tel: 028 9536 1111



Email: info@rqia.org.uk



Web: www.rqia.org.uk



Twitter: @RQIANews