The Regulation and Quality Improvement Authority

Inspection Report

15 April 2021

47 Somerton Road

Type of service: Nursing Home
Address: 47 Somerton Road, Belfast, BT15 3LH
Telephone number: 028 9077 2483

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: Somerton Homes Ltd **Responsible Individual:** Mr William Trevor Gage	**Registered Manager:** Ms Nicola Rodgers **Date registered:** 4 December 2019
Person in charge at the time of inspection: Ms Nicola Rodgers	**Number of registered places:** 40
Categories of care: Nursing (NH): LD – learning disability	**Number of patients accommodated in the nursing home on the day of this inspection:** 37
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide nursing care for up to 40 patients.	

2.0 Inspection summary

An unannounced inspection took place on 15 April 2021, from 10.15am to 2.30pm. The inspection was carried out by two pharmacist inspectors.

This inspection focused on medicines management within the home. The inspection also assessed progress with any areas for improvement identified at the last medicines management inspection.

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, which took place on 4 May 2021. The findings from the care inspection are documented in a separate report.

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 previous inspection findings, registration information, incidents and any other written or verbal information received.

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

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug records
- care plans related to medicines management
- governance and audit
- staff training and competency records
- medicine storage temperatures
- RQIA registration certificate

4.0 What people told us about the service

Staff were warm and friendly and it was evident from their interactions that they knew the patients well.

We met with two nurses, one care assistant and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed.

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.

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 completed 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 last inspection on 1 September 2020?

Areas for improvement from the last inspection on 1 September 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 16 (2) **Stated:** Third and final time	The registered person shall ensure contemporaneous nursing records are kept of all nursing interventions and procedures carried out in relation to each patient and the registered nurses have oversight of the supplementary care records. **This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.**	**Carried forward to inspection on 4 May 2021**
Area for improvement 2 **Ref:** Regulation 12 (1) (a) (b) **Stated:** Third and final time	The registered person shall ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.**	**Carried forward to inspection on 4 May 2021**
Area for improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure • staff adhere to best practice guidance for wearing of PPE and effective handwashing • items that are stored inappropriately in bathrooms are removed. • the damaged drawers in use for storage in bathrooms are replaced. **This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.**	**Carried forward to inspection on 4 May 2021**

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		Validation of compliance summary
Area for improvement 1 **Ref**: Standard 29 **Stated:** Second time	The registered person shall ensure that records of disposal include the date of disposal and are verified and signed by two registered nurses.	**Met**
	Action taken as confirmed during the inspection: Records of medicine disposal inspected contained the date of disposal and signature of two registered nurses.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that an appropriate care plan is in place to direct the care for patients with an acute infection requiring antibiotic treatment.	**Carried forward to inspection on 4 May 2021**
	This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.	
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that relevant care records are updated to reflect the changes in needs of patients. This is made in reference to, but not limited to, the changes required for medications following discharge from hospital.	**Carried forward to inspection on 4 May 2021**
	This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.	
Area for improvement 4 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that the nutritional care plans are reflective of the current SALT and IDDSI guidance.	**Carried forward to inspection on 4 May 2021**
	This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.	
Area for improvement 5 **Ref**: Standard 38 **Stated:** First time	The registered person shall ensure during the recruitment process a pre-employment health assessment is obtained in line with guidance and best practice.	**Carried forward to inspection on 4 May 2021**
	This was reviewed at the care inspection	

	on 4 May 2021. The findings are documented in a separate inspection report.	

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 local 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 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 are written and updated to provide a double check that they are 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.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. 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. Dosage directions for use were clearly recorded on the personal medication records and records of administration were maintained. Directions for use of medicines for distressed reactions were recorded in the majority of care plans. One care plan

observed did not contain directions for use and staff agreed to update the patient's care plan to reflect this. Records of administration including the reason for and outcome of administration were observed in the daily progress notes in the majority of instances. Staff were reminded to ensure the outcome and reason for administration was documented in all instances when such medicines were administered.

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.

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.

We reviewed the management of thickening agents for four patients requiring a modified diet. Care plans and speech and language (SALT) assessments were available. Records of prescribing and administration of thickening agents observed did not contain detail of the consistency levels of fluids recommended for the patient in their care plan. This is necessary to ensure the correct consistency of fluids is administered. An area of improvement was identified.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail in the care plan to direct staff if the patient's blood sugar was too low. Epilepsy management care plans were in place including the emergency management of seizures.

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. Records of medicines ordered and received reviewed during inspection were not signed and dated by a registered nurse. This is necessary to provide a clear audit trail. An area of improvement was identified.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. This included the medicines refrigerator and controlled drugs cabinet. They were tidy and organised so that medicines belonging to each patient could be easily located.

Satisfactory systems were in place for the disposal of medicines, including controlled drugs. Staff were reminded to ensure controlled drugs were denatured prior to disposal and this should be documented in the disposal records.

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. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the deputy manager for ongoing close monitoring. The records were filed once completed.

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 appropriately in a controlled drug record book.

Management and staff audited medicine administration on a regular basis within the home. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed during this inspection showed that medicines had been given as prescribed.

Several patients have their medicines administered in food/drinks to assist administration. Care plans detailing how the patients like to take their medicines were in place. Some of the practices followed by staff to assist administration mean that medicines are being administered outside the terms of their product licence. This means that the way the medicine is given has been changed to meet the need to the patient. While this is appropriate for most patients, this practice should be checked to ensure that the patient's GP agrees. Staff and management were able to confirm that the prescribers had provided written authorisation for each patient which was also detailed in each patients care plan.

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.

We reviewed the management of medicines for one patient who had a recent hospital stay and was discharged back to this home. A hospital discharge letter had been received and a copy had been forwarded to the patient's GP. Medicines had been accurately received into the home and administered in accordance with the most recent directions. The need for the personal medication records to be accurately written/rewritten following hospital discharge was reiterated.

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 audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

We discussed the medicine related incident which had been reported to RQIA since the last inspection. There was evidence that the incident 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 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. A written record was completed for induction and competency assessments.

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 the area for improvement identified at the last medicines management inspection had been addressed. Areas for improvement in relation to care were carried forward to the next care inspection. Two new areas of improvement in relation to record keeping were identified at this inspection which are detailed in the quality improvement plan.

Whilst we identified areas for improvement, we can conclude that overall patients were being administered their medicines 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 identified during this inspection are detailed in the quality improvement plan (QIP).

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

	Regulations	Standards
Total number of Areas for Improvement	3*	6*

*The total number of areas for improvement includes three under the regulations and four under the standards which have been carried forward for review at the next care inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Nicola Rodgers, 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 16 (2) **Stated:** Third and final time **To be completed by:** Immediately and ongoing (From 1 September 2020)	The registered person shall ensure contemporaneous nursing records are kept of all nursing interventions and procedures carried out in relation to each patient and the registered nurses have oversight of the supplementary care records. **This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.** Ref: 5.1
Area for improvement 2 **Ref:** Regulation 12 (1) (a) (b) **Stated:** Third and final time **To be completed by:** Immediately and ongoing (From 1 September 2020)	The registered person shall ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.** Ref: 5.1
Area for improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** Immediately and ongoing (From 1 September 2020)	The registered person shall ensure • staff adhere to best practice guidance for wearing of PPE and effective handwashing • items that are stored inappropriately in bathrooms are removed. • the damaged drawers in use for storage in bathrooms are replaced. **This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.** Ref: 5.1
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4	The registered person shall ensure that an appropriate care plan is in place to direct the care for patients with an acute infection requiring antibiotic treatment.

Stated: First time **To be completed by:** 1 November 2020	**This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report.** Ref: 5.1
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 November 2020	The registered person shall ensure that relevant care records are updated to reflect the changes in needs of patients. This is made in reference to, but not limited to, the changes required for medications following discharge from hospital.
	This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report. Ref: 5.1
Area for improvement 3 **Ref**: Standard 12 **Stated:** First time **To be completed by:** Immediately and ongoing (From 1st September 2020)	The registered person shall ensure that the nutritional care plans are reflective of the current SALT and IDDSI guidance.
	This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report. Ref: 5.1
Area for improvement 4 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 30 November 2020	The registered person shall ensure during the recruitment process a pre-employment health assessment is obtained in line with guidance and best practice.
	This was reviewed at the care inspection on 4 May 2021. The findings are documented in a separate inspection report. Ref: 5.1
Area for improvement 5 **Ref**: Standard 29 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that records for the prescribing and administration of thickening agents include the recommended consistency level i.e. Level 1, Level 2 etc. Ref:5.2.1
	Response by registered person detailing the actions taken: The care plans in place detail the level of consistency for all residents with a SALT prescribed diet and now pharmacy have been contacted to ensure consistency is also included on individual MAR sheets.
Area for improvement 6 **Ref**: Standard 29	The registered person shall ensure that records of medicines ordered and received are signed and dated by a registered nurse.

Stated: First time	Ref:5.2.2
To be completed by: Immediately and ongoing	**Response by registered person detailing the actions taken:** Records of all medicines ordered and received are signed by a registered nurse and dated the day of receiving.

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

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