The Regulation and Quality Improvement Authority

Inspection Report

10 August 2021

The Martin Residential Trust

Type of service: Nursing Home
Address: 48 Ballyclare Road, Glengormley, BT36 5HL
Telephone number: 028 9034 2365

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: The Martin Residential Trust **Responsible Individual:** Ms Lisa McFarland	**Registered Manager:** Mr Martin Kelly, registration pending
Person in charge at the time of inspection: Mr Martin Kelly	**Number of registered places:** 19
Categories of care: Nursing (NH): LD – learning disability LD(E) – learning disability – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 18
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for up to 19 patients. Patients' bedrooms are located over one floor. Patients have access to communal lounges, a dining room and a patio garden area at the rear of the home.	

2.0 Inspection summary

An unannounced inspection took place on 10 August 2021 from 10.00am to 2.25pm. The inspection was carried out by a pharmacist inspector.

This inspection focused on medicines management within the home. The inspection also assessed progress with any areas for improvement identified since the last care and medicine management inspections.

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

We met with one care assistant, the nurse in charge 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 the lounges.

Staff 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 no responses had been received.

5.0 The inspection

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

Areas for improvement from the last inspection on 10 June 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 20 (3) **Stated:** First time	The registered person shall ensure competency and capability assessments are completed with any nurse who is given responsibility of being in charge of the home in the absence of the manager. These should be available for review on inspection.	**Met**
	Action taken as confirmed during the inspection: Competency and capability assessments were completed for eight nurses in June 2021 and July 2021. Plans were in place to complete the assessments with the remaining three nurses in August 2021. Records were available for review. The manager advised that these assessments will be completed annually.	
Area for improvement 2 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure as far as is reasonably practicable that all parts of the home to which the patients have access are free from hazards to their safety, and unnecessary risks to the health and safety of patients are identified and so far as possible eliminated. This area for improvement is made with specific reference to the safe storage and supervision of substances that are hazardous to health.	**Met**
	Action taken as confirmed during the inspection: This area for improvement related to the secure storage of cleaning agents.	

	The manager advised that staff had received supervision on the secure storage of cleaning agents and that this was monitored daily by nurses and management. Cleaning agents were observed to be stored securely at the inspection.	
Area for improvement 3 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the following: • donning and doffing of personal protective equipment • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene.	**Carried forward to the next inspection**
	Action taken as confirmed during the inspection: This area for improvement was discussed with the manager who advised that he continues to reinforce the need for adherence to infection prevention and control guidance with staff. **This area for improvement was not reviewed in detail and is therefore carried forward for review at the next inspection.**	
Area for improvement 4 **Ref:** Regulation 29 **Stated:** First time	The registered person shall ensure that the Regulation 29 monitoring visits are completed in a timely manner. The registered person must ensure that a copy of the monthly monitoring reports are submitted on a monthly basis to RQIA, no later than three days after the last day of the month.	**Met**
	Action taken as confirmed during the inspection: Two Regulation 29 monitoring visits had been completed since the last inspection.	

	The registered person had submitted a copy of both monitoring reports to RQIA within the specified timeframe.	
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for improvement 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 1 October 2021	The registered person shall ensure that staff meetings take place on a regular basis, at a minimum quarterly. **Action taken as confirmed during the inspection**: The manager advised that two nurse meetings had taken place since the last inspection. The minutes were available for review. A general meeting involving all staff was scheduled. Plans were in place to have staff meetings at least quarterly. **A period of time is required to ensure compliance this area for improvement it is therefore carried forward for review at the next inspection.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref:** Standard 35.1 **Stated:** First time	The registered person shall ensure a robust system is in place to ensure compliance with best practice on infection prevention and control. **Action taken as confirmed during the inspection**: Daily handwashing audits, weekly personal protective equipment (PPE) audits and a monthly infection prevention and control (IPC) audit were completed. Copies were available for inspection.	**Met**
Area for improvement 3 **Ref**: Standard 40.2 **Stated:** First time	The registered person shall ensure all staff have a recorded annual appraisal and supervision no less than every six months. A supervision and appraisal schedule shall be in place, showing completion dates and the name of the appraiser/supervisor.	**Met**

	Action taken as confirmed during the inspection: Annual appraisals and six monthly supervisions were planned. The majority of staff had received one supervision since the last inspection. A supervision and appraisal schedule was in place, showing completion dates and the name of the appraiser/supervisor.	

No areas for improvement were identified at the last medicines management inspection which was undertaken on 19 September 2017.

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 and updated to provide a double check that they were accurate.

All patients should have care plans which detail their specific care needs and how the care is to be delivered for the individual patient. This enables each nurse to deliver the required care to each patient in a consistent manner. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets, self-administration etc.

The management of pain was discussed with nurses who advised that the majority of patients did not require regular pain relief. Nurses advised that all patients could express pain either verbally or through their behaviours. Pain was assessed regularly throughout the day and at each medicine round.

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 patients.

The management of thickening agents was reviewed for three patients. The most recent speech and language assessments were available and care plans were in place to direct staff. The current recommended consistency level was recorded on the personal medication records and records of administration were accurately maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. We reviewed the management of medicines and nutrition via the enteral route for three patients. An up to date regimen provided by a Trust dietician was in place for one of the patients only. For the remaining patients nurses were following directions which had been confirmed with a dietician via telephone call. Two nurses had not verified and signed these telephoned directions to ensure accuracy. Daily fluid intake charts were maintained. However, these had not always been accurately maintained or totalled each day. This is necessary to ensure that patients are receiving the prescribed nutrition and recommended daily fluid intake. An area for improvement was identified. The manager advised that nurses would receive supervision on the management of medicines via the enteral route and that record keeping would be monitored as part of the audit process.

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. It was noted that records for the receipt of medicines had not been maintained for the current month's supply. Omissions in the records of receipt for medicines received in previous months were also observed. Accurate records of medicines received into the home must be maintained in order to provide a clear audit trail. An area for improvement was identified.

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.

Controlled drugs are medicines which are subject to strict legal controls and legislation. Nurses were reminded that temazepam, a controlled drug in Schedule 3, must be stored in the controlled drug cabinet. This was actioned during the inspection.

Appropriate arrangements were in place for the disposal of medicines. Records of disposal were signed by two nurses. There was evidence that controlled drugs in Schedule 3 were denatured prior to disposal. Nurses were reminded that controlled drugs in Schedule 4 Part (1) must also be denatured prior to disposal.

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. However, a number of missed signatures were brought to the attention of the nurse on duty and manager who agreed to discuss this finding with all nurses and closely monitor as part of the audit process.

The management of warfarin was reviewed. Dosage directions were received via a telephone call and transcribed onto a warfarin administration chart by one nurse. This practice is unsafe as the directions may be misheard and/or incorrectly transcribed. Dosage directions for warfarin should be received in writing and nurses should refer to the original dosage directions at each administration. An area for improvement was identified. Two nurses were involved in the administration of warfarin and running balances were maintained. This is good practice.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The audits completed at the inspection indicated that medicines were being administered as prescribed. However, as shortfalls were identified in relation to a number of aspects of medicines management detailed in this report, the audit system should be further developed to include all aspects of medicines management. An area for improvement was identified.

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.

The management of medicines on admission to the home was reviewed for two patients. The patients' own medicines had been received into the home and were administered in accordance with the directions on the labels. The personal medication records had been verified and signed by two nurses from information provided by family and the medication supplied. Hand-written medication administration records had not been verified and signed by two nurses to ensure accuracy and the quantity of medicines received into the home on admission had not been recorded. An accurate list of currently prescribed medicines had not been obtained from the GP or community pharmacy and hence nurses could not be sure that the patients were administered all of their prescribed medicines or a discontinued medicine/incorrect dose.

The management of medicines on admission must be reviewed to ensure that:

- an accurate list of currently prescribed medicines is received from the hospital or GP to ensure that medicines are administered in accordance with the most recent directions
- hand-written medication administration records are verified and signed by two nurses to ensure accuracy of transcription
- the quantity of each medicine received into the home is accurately recorded to provide a clear audit trail

An area for improvement was identified.

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 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 that staff are supported. Policies and procedures should be up to date and readily available for staff.

The manager advised that nurses had received training on the management of medicines from the community pharmacist and via e-learning. Records of the competency assessments which had been completed during June and July 2021 were available for inspection.

It was agreed that the areas for improvement identified at this inspection would be discussed with all nurses for on-going 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 medicines via the enteral route, the management of medicines on admission to the home, the management of warfarin, medicine receipt records and the audit system.

Whilst we identified areas for improvement, we can conclude that overall, the patients were being 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	5*	2*

* The total number of areas for improvement includes one under the Regulations and one under the Standards which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Martin Dillon, 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 (7) **Stated:** First time **To be completed by:** From the date of the inspection onwards	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the following: • donning and doffing of personal protective equipment • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene.
	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 5.1
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:**	The registered person shall review the management of medicines administered via the enteral route as detailed in the report. Records of each patient's daily nutrition regimen should be available and daily fluid intake records should be accurately maintained. Ref: 5.2.1

From the date of the inspection	**Response by registered person detailing the actions taken**: Feeding Regimes are in place for all rsidents as per dietitan. When our service user is at school,staff are recording the volume of nutrisun and water that is administered at school between 09:30 and 15:30 in his intake chart at home thus meeting his daily intake target. Audits of intake/output charts have been implemented and the daily recordings since pharmacy inspection are being recorded accurately.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that records of medicines received into the home are accurately maintained in order to provide a clear audit trail. Ref: 5.2.2 & 5.2.4
	Response by registered person detailing the actions taken: All medications received by medicare are verified and signed in by two registered nurses at all times. Marr sheets are audited by manager and nursing staff giving a clear audit trail.
Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall review the management of warfarin to ensure that dosage directions are received in writing. Ref: 5.2.3
	Response by registered person detailing the actions taken: Following discussion with staff at GP surgery, Warfrin directions are now faxed to Martin Residential Trust and signed off by two nurses
Area for improvement 5 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall review the management of medicines on admission to ensure that: • an accurate list of currently prescribed medicines is received from the hospital or GP to ensure that medicines are administered in accordance with the most recent directions • hand-written medication administration records are verified and signed by two nurses to ensure accuracy of transcription • the quantity of each medicine received into the home is accurately recorded to provide a clear audit trail Ref. 5.2.4
	Response by registered person detailing the actions taken: Service User was admitted from their home in June. Medications were given to the previous manager in written form from the service users mother. Verifification list of medicines has been received from GP surgery.

	Supervisions and updated medications training have been completed by all nursing staff. All medications received are recrded on their Marr sheets alongside their quantity by two qualified nurses

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 1 October 2021	The registered person shall ensure that staff meetings take place on a regular basis, at a minimum quarterly.
	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
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** From the date of the inspection onwards	The registered person shall implement a robust audit system which includes all aspects of the management of medicines. Ref: 5.2.3
	Response by registered person detailing the actions taken: The audit system had been reviewed and audits are completed monthly.and daily running totals completed nightly. In addition as requested by inspector medications overview will be incoporated into the Reg 29 visit

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