Inspection Report

11 October 2021

Prospect

Type of service: Nursing Home
Address: 3 Old Galgorm Road, Ballymena, BT42 1AL
Telephone number: 028 2564 5813

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: Prospect Private Nursing Home Ltd **Responsible Individual:** Mr Thomas Mark McMullan	**Registered Manager:** Mrs Elizabeth Jane Ross **Date registered:** 1 April 2005
Person in charge at the time of inspection: Mrs Elizabeth Jane Ross	**Number of registered places:** 50
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment	**Number of patients accommodated in the nursing home on the day of this inspection:** 39
Brief description of the accommodation/how the service operates: This is a nursing home registered to provide nursing care for up to 50 patients.	

2.0 Inspection summary

An unannounced inspection took place on 11 October 2021 from 10.10am to 3.50pm. It was undertaken by a pharmacist inspector and focused on medicines management in the home.

Following discussion with the aligned care inspector, it was agreed that the area for improvement identified at the last care inspection would be followed up at the next care inspection.

Review of medicines management found that patients were being administered their medicines as prescribed. Arrangements were in place to ensure that staff received training and were deemed competent in medicines management. Most of the medicine records were well maintained and all medicines were stored securely.

However, the inspection findings indicate that the governance arrangements for medicines management require review, as improvement is necessary in the completion of medicine administration records, care plans, medicine related incidents and the storage of medicines.

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. The inspection was completed by reviewing a sample of medicine related records and care plans, medicines storage and the auditing systems used to ensure the safe management of medicines. Staff views were also obtained.

4.0 What people told us about the service

Patients appeared relaxed and content in the home. Staff interactions with patients and their relatives were warm, friendly and supportive. It was evident they knew the patients well and were knowledgeable about the patients' medicines.

During discussions with some of the staff on duty, they said they enjoyed their job, the teamwork and the support provided. They expressed satisfaction with how the home was managed and said that they had the necessary training to look after the patients.

All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered 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, three relatives had completed and returned questionnaires to RQIA. The responses were positive, indicating they were 'very satisfied' with the care provided.

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 care inspection on 21 January 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13(1)(a) (b) **Stated:** First time	The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record.	**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.	

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 or hospital appointments.

The majority of personal medication records reviewed at the inspection were accurately maintained; however, the dosage directions on some topical medicines required updating (See also Section 5.2.3). A small number of records did not include the patient's photograph; this is good practice to assist with the safe administration of medicines. The manager agreed to address this after the inspection. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to check that they were 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, diabetes etc.

There was evidence that medicine related care plans were in place; however, whilst some were up to date, one regarding specific parameters around medicines administration was not in place and others required updating. As these care plans were evaluated each month, the need to check the detail was discussed. This was identified as an area for improvement.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The 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.

However, robust systems were not in place to monitor medicines which expire shortly after opening, for example, eye drops and insulin. A number of bottles of expired eye drops were noted and removed from the medicine trolley for disposal. Opened insulin pen devices were not stored in accordance with the manufacturer's instructions and the date of opening was not recorded. Medicines must be correctly stored and must not be administered once the expiry date has been reached. Advice and guidance was provided. An area for improvement was identified.

Appropriate arrangements were in place for the disposal of medicines.

5.2.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of medicine administration records was reviewed. Most were found to have been maintained in a satisfactory manner. However, for three medicines, there was evidence of code-copying, where staff had signed the medicines codes from the day before and had not administered the medicine as prescribed. Medicines must be administered as prescribed and accurate records maintained. An area for improvement was identified.

In relation to topical medicines administered by care staff, it was established that the nurse completed the records. The staff member preparing and administering a medicine should sign the records. This was discussed with management and advice given. An area for improvement was identified.

Management and staff audited medicine administration on a regular basis and records were maintained. Their audits focussed mainly on tablets and capsules and did not routinely include other formulations of medicines, such as inhalers, liquids, eye preparations, and insulin. The audit records showed some discrepancies; however, there was no evidence that these had been shared with management or followed up for corrective action. It was noted that correction fluid had been used; this should not be used on any medicine related records. An effective auditing process should be developed and implemented. See Section 5.2.5.

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 process for patients new to the home or returning to the home after receiving hospital care was reviewed. Written confirmation of the patient's medicine regime was received at, or prior to admission. Satisfactory arrangements were in place to ensure the medicine information was accurately recorded on the personal medication records and records of incoming and outgoing medicines.

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. A robust medicines management audit system helps staff to identify medicine related incidents.

Whilst there was evidence that the medicine incidents reported to RQIA had been managed appropriately, the audit records and the controlled drug records indicated that there had been discrepancies in three controlled drug stock balances. The manager had not been informed of these incidents. An area for improvement was identified. Following the inspection, the manager investigated these observations and provided a satisfactory response.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in medicines administration as detailed in Section 5.2.3. A review of the monthly management audits indicated that the issues raised at this inspection had not been identified. A robust audit system, which covers all aspects of medicines management, is necessary to ensure that safe systems are in place and learning from errors/incidents can be actioned and shared with staff. An area for improvement was identified. The QIP from this inspection should be incorporated into the audit process to ensure sustained improvement.

5.2.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported. Policies and procedures should be up to date and readily available for staff use.

Systems were in place to ensure that nursing staff and care staff who were delegated medicine tasks, had received training in medicines management. Competency had been assessed following induction and annually thereafter. A sample of records to indicate that staff were trained and deemed competent in medicines management was provided. Due to the inspection findings, it was suggested that staff should receive training in the areas identified.

.

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 with respect to medicines management.

Whilst areas for improvement were identified, we can conclude that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed. A review of the current auditing process to ensure this covers all aspects of medicines will assist management and staff in addressing the areas for improvement identified. This inspection resulted in six new areas for improvement.

We would like to the 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 Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	4*	3

* The total number of areas for improvement includes one which has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Elizabeth Ross, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that medicines are stored at the correct temperature and are not administered after the expiry date has been reached. Ref: 5.2.2 **Response by registered person detailing the actions taken**: Staff reminded in relation to storage of medications and these are being monitored via the auditing process.
Area for improvement 2 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that all medicines are administered as prescribed with accurate records of administration maintained. Ref: 5.2.3 **Response by registered person detailing the actions taken**: Staff advised to ensure medicines are administered as prescribed and the recording of these is accurate,
Area for improvement 3 **Ref**: Regulation 30 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that medicine related incidents are identified and reported to management; and RQIA as necessary. Ref: 5.2.5 **Response by registered person detailing the actions taken**: Staff reminded of the incident recording process and these will be carried forward and reported appropriately.
Area for Improvement 4 **Ref:** Regulation 13(1)(a)(b) **Stated:** First time **To be completed by:** With immediate effect (21 January 2021)	The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record. **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

Action required to ensure compliance with the Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that medicine related care plans are in place and up to date. Ref: 5.2.1
	Response by registered person detailing the actions taken: Care plans updated and added to the audit for this purpose
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall develop the auditing process to ensure that it is effective at identifying shortfalls in medicines management and covers all aspects of medicines management. Ref: 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: Auditing process updated and remains under review.
Area for improvement 3 **Ref:** Standard 29 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall review the management of topical preparations in relation to administration and record keeping. Ref: 5.2.1 & 5.2.3
	Response by registered person detailing the actions taken: Training currently being updated and added to the induction programme.

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