The Regulation and Quality Improvement Authority

Inspection Report

7 March 2022

Jordanstown

Type of service: Nursing Home
Address: 1a Old Manse Road, Jordanstown, BT37 0RU
Telephone number: 028 9085 2258

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: Four Seasons Health Care **Responsible Individual:** Mrs Natasha Southall	**Registered Manager:** Ms Debby Gibson – Acting manager
Person in charge at the time of inspection: Ms Debby Gibson	**Number of registered places:** 53
Categories of care: Nursing (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:** 28
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for up to 53 persons. The home is located over three floors with patient's bedrooms located on the ground and first floors.	

2.0 Inspection summary

An unannounced inspection took place on 7 March 2022, from 10.45am to 2.45pm. The inspection was completed by a pharmacist inspector.

The inspection focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

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.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary to ensure that medicines were managed safely in accordance with legislation. Areas for improvement are detailed in the quality improvement plan and include the management of medicines prescribed for distressed reactions, out of stock medicines, medicine audits and records for the receipt of medicines.

Following the inspection the findings were discussed with the Senior Pharmacist Inspector in RQIA. RQIA decided that a period of time would be given to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement. Feedback of the inspection was also provided via telephone to Mrs Ruth Burrows, Regional Manager.

RQIA would like to thanks patients and staff for their assistance throughout the inspection.

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 examining 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. Staff views were also obtained.

4.0 What people told us about the service

To reduce footfall throughout the home, the inspector did not meet any patients. Patients were observed to be relaxing in communal lounges in the home.

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

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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.

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 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 the last inspection?

Areas for improvement from the last inspection on 25 January 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 19 (1) (a) Schedule 3 (3) (k) **Stated:** Second time	The registered person shall ensure accurate and contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient, in accordance with NMC guidelines. **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.**	**Carried forward to the next inspection**
Area for Improvement 2 **Ref:** Regulation 13 (7) **Stated:** Second 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 • staff knowledge and practice regarding hand hygiene • decluttering of storage cupboards • adherence to the national colour coding scheme. **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.**	**Carried forward to the next inspection**

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for improvement 1 **Ref:** Standard 46.2 **Stated:** Second time	The registered person shall ensure a more robust system is in place to ensure compliance with best practice on infection prevention and control. **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.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref**: Standard 11 **Stated:** First time	The registered person shall ensure the programme of activities is displayed in a suitable format in the home and is accessible for all patients. This should be developed in consultation with the patients and reviewed at least twice yearly to ensure it meets patients changing needs. Individual activity assessments should be completed and reviewed as required to inform and compliment patient centred care plans. A contemporaneous record of activities delivered must be retained. Activities must be integral part of the care process with daily progress notes reflecting activity provision. **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.**	**Carried forward to the next inspection**
Area for improvement 3 **Ref:** Standard 3.2 **Stated:** First time	The registered person shall ensure patients are effectively involved in making decisions about their treatment. Care records should clear evidence discussions had and decisions made with the patient. This area or improvement is made with specific reference to the use of bedrails. **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.**	**Carried forward to the next inspection**

Area for improvement 4 **Ref:** Standard 4.8 **Stated:** First time	The registered person shall ensure where the outcome of a bedrail assessment identifies that bedrails may be used, alternatives should be tried and records maintained of what alternatives were considered. **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.**	**Carried forward to the next inspection**
Area for improvement 5 **Ref**: Standard 21.1 **Stated:** First time	The registered person shall ensure that patients' wound care needs are managed in an effective manner in keeping with care plan directions. Records should be updated in a timely manner when the patients need change. **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.**	**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 may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the 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 personal medication records reviewed at the inspection were accurate and up to date. 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 confirm 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.

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 nurses 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 nurses 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 the management of distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. However, the reason for and outcome of each administration was not routinely recorded. An area for improvement was identified.

The management of pain was discussed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place and reviewed regularly.

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 and nutritional supplements was reviewed for two patients. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was too high or too low.

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 the majority of medicines were available for administration when patients required them. However, it was identified that two medicines had been out of stock for a period of four days resulting in missed doses. In addition, a controlled drug pain patch prescribed to be administered once weekly had been administered one day late as it had been out of stock. These discrepancies were escalated to the manager on the day of the inspection for immediate action and investigation.

Incident reports detailing the actions taken and measures implemented to prevent a recurrence was submitted to RQIA on 8 March 2022. Patients must have a continuous supply of their medications as missed doses or late administrations can impact upon their health and well-being. 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

Satisfactory arrangements were in place for the safe 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 the medicines administration records was reviewed. The records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for audit or review.

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 in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

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

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 including a medicine prescribed for Parkinson's disease. An eye drop preparation was in use passed the stated expiry date and had not been replaced. As stated in Section 5.2.2, three medicines had not been administered as prescribed due to being out of stock. The internal audit process was not effective in identifying deficits and requires review. 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 for one patient recently admitted to the home from their usual residence was reviewed. A current list of the patient's medicines had been obtained from the GP and this was shared with the community pharmacist. The personal medication record had been written accurately and checked by a second member of staff. Medicines which had been received into the home on admission had not been recorded in the medicine receipt book. It could therefore not be determined if medicines had been administered as prescribed. 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. A robust audit system will help staff to identify medicine related incidents.

As stated in Section 5.2.3 the findings of this inspection indicate that the auditing system is not robust and hence incidents may not be identified. A more robust audit system which covers all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.

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 they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

The manager agreed to share the findings of this inspection with all nurses for ongoing improvement.

6.0 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 or the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	4*	7*

* The total number of areas for improvement includes seven which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Debby Gibson, Manager, as part of the inspection process. Feedback of the inspection was also provided via telephone to Mrs Ruth Burrows, Regional Manager. 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 19 (1) (a) Schedule 3 (3) (k) **Stated:** Second time **To be completed by**: 25 February 2022	The registered person shall ensure accurate and contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient, in accordance with NMC guidelines.
	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 (7) **Stated:** Second time **To be completed by**: 25 February 2022	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 • staff knowledge and practice regarding hand hygiene • decluttering of storage cupboards • adherence to the national colour coding scheme.
	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 3 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** Immediately from the date of inspection (7 March 2022)	The registered person shall ensure that patients have a continuous supply of their prescribed medicines. Ref: 5.2.2
	Response by registered person detailing the actions taken: A full baseline audit was completed by the Home Manager and the Care Quality Manager to rule out any further potential shortfalls. A meeting was held by the Regional Manager and Home Manager with the Pharmacy Manager and an action plan was put in place to address communication issues. A Pharmacy Advice Visit has also been completed. Random checks are being carried out by members of the Senior Management Team to monitor compliance. Face to Face Medication Training has been arranged for all nursing staff.

Area for improvement 4 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** Immediately from the date of inspection (7 March 2022)	The registered person shall implement a robust audit system which covers all aspects of the management of medicines. Any shortfalls identified should be detailed in an action plan and addressed. Ref: 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: The Manager's monthly audit is completed and an action plan put in place to address any issues highlighted. A new night audit schedule has been implemented and the Home Manager has oversight of same. Staff are recording a daily running balance on the MAR sheet. Random checks are being carried out by members of the Senior Management team to monitor compliance. All staff are to attend Face to Face Medication Training.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 46.2 **Stated:** Second time **To be completed by:** 25 February 2022	The registered person shall ensure a more robust system is in place to ensure compliance with best practice on infection prevention and control.
	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 11 **Stated:** First time **To be completed by:** 25 February 2022	The registered person shall ensure the programme of activities is displayed in a suitable format in the home and is accessible for all patients. This should be developed in consultation with the patients and reviewed at least twice yearly to ensure it meets patients changing needs. Individual activity assessments should be completed and reviewed as required to inform and compliment patient centred care plans. A contemporaneous record of activities delivered must be retained. Activities must be integral part of the care process with daily progress notes reflecting activity provision.
	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 3 **Ref:** Standard 3.2 **Stated:** First time **To be completed by:** Immediate action required (25 January 2022)	The registered person shall ensure patients are effectively involved in making decisions about their treatment. Care records should clear evidence discussions had and decisions made with the patient. This area or improvement is made with specific reference to the use of bedrails.
	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 4 **Ref:** Standard 4.8 **Stated:** First time **To be completed by:** Immediate action required (25 January 2022)	The registered person shall ensure where the outcome of a bedrail assessment identifies that bedrails may be used, alternatives should be tried and records maintained of what alternatives were considered.
	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 5 **Ref**: Standard 21.1 **Stated:** First time **To be completed by:** 25 February 2022	The registered person shall ensure that patients' wound care needs are managed in an effective manner in keeping with care plan directions. Records should be updated in a timely manner when the patients need change.
	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 6 **Ref**: Standard 18 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (7 March 2022)	The registered person shall ensure that the reason for and outcome of administration of medicines administered for the management of distressed reactions is consistently recorded. Ref: 5.2.1
	Response by registered person detailing the actions taken: All PRN protocols have been reviewed since the inspection and are now in place. It has been emphasised to staff the rationale for consistent recording of the outcome of any PRN medication administered. Spot checks have been implemented to monitor.

Area for improvement 7 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure records of the receipt of medicines, including medicines brought into the home by newly admitted patients, are fully and accurately maintained. Ref: 5.2.4
To be completed by: Ongoing from the date of inspection (7 March 2022)	**Response by registered person detailing the actions taken:** Medications received into the Home for current residents are recorded on the MAR including those received from the Pharmacy mid-cycle. A book is in place to record medications brought in from home relating to respite admissions and it is also completed for any medication to be returned on discharge.

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

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