Inspection Report
7 October 2020

Broadways Private Nursing Home

Type of Service: Nursing Home
Address: Broadway, Main Street, Larne, BT40 1LT
Tel No: 028 2827 3464
Inspector: Rachel Lloyd

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home registered to provide nursing care for up to 33 patients.

2.0 Service details

Organisation/Registered Provider: Broadways Private Nursing Home Ltd **Responsible Individual:** Mrs Barbara Sloan	**Registered Manager and date registered:** Mrs Jacqueline Davey 7 March 2012
Person in charge at the time of inspection: Mrs Jacqueline Davey	**Number of registered places:** 33 A maximum of 2 patients in category NH-PH
Categories of care: Nursing Home (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:** 25

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 7 October 2020 from 10.00 to 13.10. Short notice of the inspection was provided in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

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

Progress in any areas for improvement identified at or since the last care inspection will be assessed at the next care inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information 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 with regard to the management of medicines.
- observed practice and daily life.
- reviewed documents to confirm that appropriate records were kept.

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

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug record book
- care plans related to medicines management
- staff training and competency assessments records regarding the management of medicines
- medicine audits
- medicine storage temperatures records

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	*6	*4

*The total number of areas for improvement includes four under the Regulations and two under the Standards that are carried forward to the next care inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Jacqueline Davey, Registered Manager, during the inspection and, the deputy manager, by telephone following the inspection to confirm some details, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

5.0 What has this service done to meet any areas for improvement identified at or since the last medicines management (19 September 2018) and care inspections (23 September 2019)

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that there are robust systems in place to manage the self-administration of medicines.	**Met**
	Action taken as confirmed during the inspection: There were no patients responsible for self-administration at the time of this inspection. The manager confirmed that self-administration procedures had been reviewed to include care plans, records and staff discussion. This area for improvement was assessed as met.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that the management of eye preparations for one patient is investigated and the outcomes reported as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: Following the last medicines management inspection the manager confirmed that the prescriber had been contacted, medication reviewed and procedures reviewed.	
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time	The registered person shall review the management of distressed reactions to ensure that a patient specific care plan is maintained, that the prescriber is made aware of frequent use and the reason for and outcome of administration is recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: In the sample of records examined, a care plan was in place, the prescriber was aware of and reviewing frequent use where necessary; and the reason for and outcome of administration were recorded in the majority of cases.	

Areas for improvement from the last care inspection		
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 21 **Stated:** Second time	The registered person shall ensure that no individuals are employed within the home until all the information and documents as outlined in paragraphs 1 to 7 of Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005 have been obtained.	**Carried forward to next care inspection**
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk and spread of infection.	**Carried forward to next care inspection**
Area for improvement 3 **Ref:** Regulation 13 (1)(a) (b) **Stated:** First time	The registered person shall ensure the following in relation to the provision of wound care for all patients: • that care plan(s) are in place which accurately describe the assessed needs of patients • that nursing staff shall record all wound care interventions in an accurate, thorough and consistent manner in compliance with legislative and best practice standards	**Carried forward to next care inspection**
Area for improvement 4 **Ref:** Regulation 29 **Stated:** First time	The registered person shall ensure that a robust system of monthly quality monitoring visits is completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes 2015. Such visits should include evidence of reviewing care records/care record audits and include time bund action plans to drive quality improvement and address any deficits identified by current quality improvement plans as outlined by RQIA.	**Carried forward to next care inspection**
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		
Area for improvement 1 **Ref:** Standard 11 **Stated:** First time	The registered person shall ensure that robust governance arrangements are in place which ensure the provision of a programme of events and activities throughout the home. This programme should aim to provide positive and meaningful outcomes for patients and be displayed in a suitable format within appropriate locations.	**Carried forward to next care inspection**

Area for improvement 2 **Ref:** Standard 35 **Stated:** First time	The registered person shall ensure that a robust system of audits is implemented and maintained to promote and make proper provision for the nursing, health and welfare of patients. Such governance audits shall be completed in accordance with legislative requirements, minimum standards and current best practice, specifically, care record audits and patients' weights audits.	**Carried forward to next care inspection**

6.0 What people told us about this service?

On the day of inspection we spoke to the manager, deputy manager and two other nurses on duty. The nurses expressed satisfaction with how the home was managed and stated that they found their work fulfilling. They also said that they had the appropriate training to look after patients and meet their needs.

All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed. One nurse had painted nails and one was wearing a stoned ring, the manager had already identified this and agreed to follow up immediately in the interests of infection prevention and control.

We did not speak to patients on this occasion, although good interactions were observed between staff and patients. Staff were warm and friendly and obviously knew the patients well.

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, no questionnaires had been received by RQIA.

7.0 Inspection findings

7.1 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 medical 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 may be done by the GP, medical consultant or the pharmacist.

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 contained a list of all 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, transfers to hospital. Most of these records had been well maintained. A second member of staff had checked and signed these records when they were updated to

provide a double check that they were accurate. However, three of the records examined did not match the printed medication administration records (MARs).

No written confirmation of prescribed medicines was held for most patients, other than hospital discharge letters where applicable; therefore there was not a robust system for staff to check personal medicine records against the current prescription. For the relevant patients' records examined, this was followed up immediately with the prescriber and it was confirmed that no omissions had taken place and the patients had received their medicines as prescribed. Written confirmation of the most recent prescription should be held and/or requested from the prescriber for a new or readmission in order to confirm the accuracy of the personal medication record. The personal medication record and MAR must match and reflect the prescriber's most recent instructions; any discontinuations must be promptly recorded. Two areas for improvement were identified.

All patients should have care plans which detail their specific care needs and how care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for two patients. See section 5.0.

We reviewed the management of pain for two patients. Care plans were in place. Staff were familiar with how each patient expressed their pain and pain relief was administered as prescribed.

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.

We reviewed the management of thickening agents and nutritional supplements for one patient. A speech and language assessment report and care plan was in place. Records of prescribing and administration were maintained.

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

Medicines must be available to ensure that they are administered to patients as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

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

The medicines storage area was locked securely when not in use. It was tidy and organised so that medicines belonging to each patient could be easily located. The medicines currently in use were stored within medicine trolleys that were also securely stored so that there could be no unauthorised access. Medicine cupboards were locked. Controlled drugs were stored in a controlled drug cabinet. When medicines needed to be stored at a colder temperature, they

were stored within the medicine refrigerator. The temperature of this refrigerator was monitored and the current temperature was found to be satisfactory. However, maximum and minimum temperatures were often outside of the required range of 2-8°C. This had not been recognised or addressed by staff when recording temperatures over the last month. This is necessary to ensure that the medicines, which included flu vaccines and insulin, are suitable for use. An area for improvement was identified.

Medicine disposal was discussed. Controlled drugs were denatured prior to disposal and there were systems in place to ensure discontinued medicines were safely disposed of. Disposal of medicine records were completed so that medicines could be accounted for.

7.3 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.

Medicine administration records must be completed when medicines are administered to a patient. A review of a sample of these records indicated that they had been accurately completed.

The manager and nurses audit medicine administration on a regular basis within the home. The audit records showed that medicines had been given as prescribed. The date of opening was recorded on the majority of medicines so that they could be easily audited; this is good practice. However, the areas identified for improvement during the inspection had not been identified through the audit procedures in place. To improve the ability to recognise discrepancies and areas for improvement, the process must be robust and include all aspects of the management of medicines; staff must be aware of what is expected. An area for improvement was identified.

Audits completed during this inspection showed that medicines had been administered as prescribed.

7.4 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 care setting to another.

We reviewed the management of medicines on admission from hospital to the home for one patient. In order to ensure the safe management of medicines during this transfer of care, a hospital discharge letter had been received and a copy had been forwarded to the patient's GP. The personal medication record had been accurately written. Medicines had been administered in accordance with the most recent directions.

7.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicine incidents occur within homes. It is important that there are systems in place that 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 process also facilitates the identification of incidents. See section 7.3.

There had been one medication related incident identified since the last medicines management inspection. There was evidence that the incident had been investigated and learning had been shared with staff.

7.6 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 received a structured induction which includes medicines management when that forms part of their role. Medicines update training had been completed by the nurses between April and October 2019. Competency was assessed following induction and annually thereafter and a written record completed. This year's competency assessment had yet to be completed, however the manager confirmed these would be completed following the inspection.

8.0 Evaluation of Inspection

This inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led regarding the management of medicines.

We can conclude that overall, patients were being administered their medicines as prescribed and the areas for improvement identified at the last medicines management inspection had been addressed. However, we did identify that some areas of the management of medicines were not robust and these are detailed in the quality improvement plan.

We would like to thank the patients and staff for their assistance throughout the inspection.

9.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Jacqueline Davey, Registered Manager, during the inspection and the deputy manager, by telephone following the inspection to confirm some details, as part of the inspection process. The timescales commence from the date of inspection.

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.

9.1 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

9.2 Actions to be taken by the home

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that personal medication records and medication administration records match and reflect the prescriber's most recent instructions; any discontinuations must be promptly recorded. Ref: 7.1
	Response by registered person detailing the actions taken: All records checked by two staff and all correlated. Staff memo to all nurses to ensure this practice is continued.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the medicine refrigerator is managed appropriately so that maximum and minimum temperatures remain within the required range of 2-8°C. An accurate record must be maintained and immediate action taken when deviations are identified. Ref: 7.2
	Response by registered person detailing the actions taken: Following inspection, a new checking sheet was devised. However, problems still persisted and so a new fridge was acquired. New sheet ongoing.
Area for improvement 3 **Ref:** Regulation 21 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that no individuals are employed within the home until all the information and documents as outlined in paragraphs 1 to 7 of Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005 have been obtained. Ref: 5.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 4 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk and spread of infection. Ref: 5.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.

Area for improvement 5 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in relation to the provision of wound care for all patients: • that care plan(s) are in place which accurately describe the assessed needs of patients • that nursing staff shall record all wound care interventions in an accurate, thorough and consistent manner in compliance with legislative and best practice standards. Ref: 5.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 6 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that a robust system of monthly quality monitoring visits is completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes 2015. Such visits should include evidence of reviewing care records/care record audits and include time bund action plans to drive quality improvement and address any deficits identified by current quality improvement plans as outlined by RQIA. Ref: 5.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that written confirmation of patients' medicines and any new medicines or changes is in place in order to confirm the accuracy of the personal medication record. Ref: 7.1
To be completed by: 7 November 2020	**Response by registered person detailing the actions taken:** All nurses and pharmacy have been reminded that a copy of all prescriptions provided must be kept in the home. Any changes made to the Kardex etc should be signed by 2 staff and correlated across all paperwork.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that the audit process for the management of medicines is robust and include all aspects of the management of medicines; staff must be aware of what is expected. Ref: 7.3
To be completed by: 7 November 2020	**Response by registered person detailing the actions taken:** A robust audit system is in place. All nursing staff have been given a

	supervision session on auditing to ensure a robust audit system is continuous.

Area for improvement 3 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 4 November 2019	The registered person shall ensure that robust governance arrangements are in place which ensure the provision of a programme of events and activities throughout the home. This programme should aim to provide positive and meaningful outcomes for patients and be displayed in a suitable format within appropriate locations. Ref: 5.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 4 **Ref**: Standard 35 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that a robust system of audits is implemented and maintained to promote and make proper provision for the nursing, health and welfare of patients. Such governance audits shall be completed in accordance with legislative requirements, minimum standards and current best practice, specifically, care record audits and patients' weights audits. Ref: 5.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.

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

The Regulation and Quality Improvement Authority

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