Inspection Report

1 August 2023

Lakeview

Type of service: Nursing
Address: 1c Orchard Road, Crumlin, BT29 4SD
Telephone number: 028 9442 2733

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: Spa Nursing Home Ltd **Responsible Individual:** Mr Christopher Philip Arnold	**Registered Manager:** Mr Binu Chacko **Registered**: 15 July 2022
Person in charge at the time of inspection: Mr Binu Chacko	**Number of registered places:** 42 There shall be a maximum number of 21 residents within NH-DE Category of Care.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia 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:** 34
Brief description of the accommodation/how the service operates: Lakeview is a registered nursing home which provides nursing care for up to 42 patients. The home is divided over two floors. The ground floor provides nursing care for people with primary needs relating to old age and physical disability. The first floor provides nursing care for people living with dementia. Both floors provide care for people at the end of life.	

2.0 Inspection summary

An unannounced inspection took place on 1 August 2023, from 9.45am to 1.55pm. This was completed by a pharmacist inspector. The inspection focused on medicines management within the home.

The areas for improvement identified at the last care inspection have been carried forward for follow up at the next care inspection.

Review of medicines management found that mostly satisfactory arrangements were in place for the safe management of medicines. However, improvements in a couple of areas for the management of medicines were necessary.

Areas for improvement are detailed in the quality improvement plan (QIP) and include the management of insulin and the recording of medicines management audit activity.

Whilst two areas for improvement were identified, it was concluded that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed. Medicines were stored safely and securely and staff with responsibility for medicines management had received relevant training. The manager agreed to share the findings of this inspection with staff in order to drive and sustain improvements.

RQIA would like to thank the manager 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. The inspector also spoke to staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with the manager and the two registered nurses on duty.

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

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 14th April 2022		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 22 **Stated:** Second time	The registered person shall ensure that a falls prevention review is carried out for the identified patient, that onward referral is conducted where indicated and that staff adhere to the resulting care plan.	**Carried forward to the next inspection**
	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.	
Area for improvement 2 **Ref:** Standard 39 **Stated:** First time	The registered person shall ensure that enhanced dementia training is provided to staff. Training to include a focus on behaviours associated with dementia that can be challenging.	**Carried forward to the next inspection**
	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.	
Area for improvement 3 **Ref:** Standard 14 Criteria 26 **Stated:** First time	The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff members undertaking the reconciliation.	**Carried forward to the next inspection**
	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.	

Area for improvement 4 **Ref:** Standard 23 Criteria 2 **Stated:** First time	The registered person shall ensure that pressure preventative care plans are in place for patients assessed as being at risk of skin breakdown. Care plans to stipulate recommended frequency of repositioning and detail any specialist equipment in use, such as pressure relieving mattresses.	**Carried forward to the next inspection**
	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.	
Area for improvement 5 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure that patients' personal hygiene items are stored appropriately to maintain infection prevention and control standards.	**Carried forward to the next inspection**
	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.	

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 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 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 mostly 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 state that they were accurate.

However, for insulin entries the doses were specified using the abbreviation “iu.” (signifying “international units”). The use of this abbreviation has the potential of causing an error in the insulin dose administered due to nurses misinterpreting the information. An area for improvement was made in relation to the management of insulin (also see section 5.2.2)

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 staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient’s distress and if the prescribed medicine is effective for the patient.

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. Staff knew how to recognise a change in a patient’s behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome of each administration.

The management of pain was discussed. The manager and 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 were reviewed. A speech and language assessment report and care plan was 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 low. Care plans were also in place where patients were prescribed medication for seizure management and where a patient was administered medication covertly.

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. The manager advised that there was 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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

A couple of insulin pen devices did not have the date of opening recorded. This information is needed to ensure that the insulin is not used beyond its recommended shelf life once opened and also to facilitate audit activity. An area for improvement was made in relation to the management of insulin (also see section 5.2.1).

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.

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 should be 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. However, whilst the manager was able to provide recorded evidence that medicines prescribed for administration on a “when necessary” basis are audited, there was no recorded evidence of audits performed on medicines prescribed for administration on a regular basis. The manager stated that these medicines are audited at the end of each four-week medication cycle but accepted that this audit activity is not recorded. 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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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.

The manager was familiar with the type of incidents that should be reported.

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. The manager agreed to investigate the discrepancy in one audit and submit a notification to RQIA. The notification was submitted to RQIA on 1 August 2023.

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 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.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, 2022.

	Regulations	Standards
Total number of Areas for Improvement	0*	7*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Binu Chacko, 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 Care Standards for Nursing Homes, April 2022	
Area for improvement 1 **Ref:** Standard 22 **Stated:** Second time **To be completed by:** With immediate effect (14 April 2022)	The registered person shall ensure that a falls prevention review is carried out for the identified patient, that onward referral is conducted where indicated and that staff adhere to the resulting care plan.
	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 39 **Stated:** First time **To be completed by:** 30 June 2022	The registered person shall ensure that enhanced dementia training is provided to staff. Training to include a focus on behaviours associated with dementia that can be challenging.
	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 14 Criteria 26 **Stated:** First time **To be completed by:** 31 May 2022	The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff members undertaking the reconciliation.
	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 23 Criteria 2 **Stated:** First time **To be completed by:** With immediate effect (14 April 2022)	The registered person shall ensure that pressure preventative care plans are in place for patients assessed as being at risk of skin breakdown. Care plans to stipulate recommended frequency of repositioning and detail any specialist equipment in use, such as pressure relieving mattresses.
	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 46 **Stated:** First time **To be completed by:** With immediate effect (14 April 2022)	The registered person shall ensure that patients' personal hygiene items are stored appropriately to maintain infection prevention and control standards.
	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 29 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (1 August 2023)	The registered person shall ensure that the arrangements for the management of insulin are reviewed. This relates specifically to not using abbreviations when recording insulin doses on the personal medication records and always recording the dates of opening of insulin pen devices. Ref: 5.2.1 and 5.2.2
	Response by registered person detailing the actions taken: The Registered Manager has rewritten the kardex of any resident prescribed insulin to ensure abbreviations are not used and has addressed with nursing staff the importance of dating all insulin pen devices when opened. The Registered Manager will continue to monitor this within the auditing process.
Area for improvement 7 **Ref:** Standard 28 **Stated:** First time **To be completed by:**	The registered person shall ensure that all medicines management audit activity is recorded. This relates specifically to the recording of audits performed on medicines prescribed for regular administration. Ref: 5.2.3

Ongoing from the date of inspection (1 August 2023)	**Response by registered person detailing the actions taken:** The Registered Manager has commenced auditing of regular prescribed medication to ensure that all medicine management activity is recorded.

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