The Regulation and Quality Improvement Authority

Inspection Report

15 November 2021

Marina Care Home

Type of service: Nursing
Address: Shore Road, Ballyronan, BT45 6JA
Telephone number: 028 7941 8770

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: Burnview Healthcare Ltd **Responsible Individual:** Mrs Briege Agnes Kelly	**Registered Manager:** Mrs Una McTaggart **Date registered:** 11 November 2016
Person in charge at the time of inspection: Mrs Una McTaggart	**Number of registered places:** 32 Including one named patient in category NH-LD (E).
Categories of care: Nursing (NH) I - Old age not falling within any other category NH-LD(E) – Learning disability – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 29
Brief description of the accommodation/how the service operates: This is a nursing home registered to provide nursing care for up to 32 patients.	

2.0 Inspection summary

An unannounced inspection took place on 15 November 2021, from 10.15am to 2.30pm. The inspection was undertaken by a pharmacist inspector and focused on medicines management within the home.

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.

Review of medicines management found that patients were being administered their medicines as prescribed. There were arrangements for auditing medicines and medicine records were well maintained. Systems were in place to ensure that staff were trained and competent in medicines management. No new areas for improvement were identified.

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, reported incidents and correspondence. To complete the inspection the following were reviewed: a sample of medicine related records, 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

Patients were observed to be relaxed and content in the home. The inspector met with two nurses and the manager. Staff were warm and friendly and it was evident from discussions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The nurses spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

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, three questionnaires had been returned to RQIA. All responses indicated that the respondent was satisfied/very satisfied with the care provided/received. No staff responses were received.

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 21 September 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 27 **Stated:** Second time	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed and that equipment is stored appropriately. **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 21 (5) (d) (i) **Stated:** First time	The registered person shall ensure a robust system is in place to regularly monitor staff registration with NISCC within the required time frame. **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 3 **Ref:** Regulation 12 (1) **Stated:** First time	The registered person shall ensure the following in regards to the repositioning of patients: • that patients are repositioned in keeping with their prescribed care • that repositioning records are accurately and comprehensively maintained at all times • pressure relieving mattresses are effectively managed in keeping with the assessed needs of patients. **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 summary
Area for improvement 1 **Ref:** Standard 11 **Stated:** First time	The registered person shall ensure that the provision of activities in the home is reviewed to ensure a contemporaneous record of activities delivered, patient engagement and participation is retained.	**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 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 the GP, the pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by a community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had verified and signed the personal medication records when they were written and updated to provide a check that they were accurate. It was agreed that records no longer in use would be marked as discontinued and archived promptly.

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 safe 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 etc.

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 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 distressed reactions was reviewed for four patients. The nurses on duty knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on personal medication records and care plans directing the use of these medicines were in place. Records of administration were maintained. The reason for and outcome of administration were recorded on the majority of occasions. This should be recorded on all occasions and it was agreed that this would be addressed.

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 were in place.

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 was reviewed for three patients. A speech and language assessment report (SALT) and care plan was in place for each patient. Records of prescribing and administration which included the recommended consistency level were maintained.

Several patients have their medicines crushed and/or administered in food/drinks to assist administration. Care plans detailing how the patients like to take their medicines were in place. Prescribers had provided written authorisation for each patient.

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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

It was agreed that the thermometer on the medicines refrigerator would be reset every day after recording temperatures. It was also agreed that spacer devices for inhaled medicines would be stored covered for infection prevention and control purposes.

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. The records had been completed in a satisfactory manner. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. 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 were recorded appropriately in a controlled drug record book.

Management and staff audited the management and administration of medicines on a regular basis. The date of opening was recorded on medicines so that they could be easily audited. Where shortfalls had been identified action plans were developed and implemented. It was agreed that records of the administration of medicines on a "when required" basis for the management of distressed reactions would be included in audit procedures.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

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 recently admitted patients or patients returning to the home following discharge from hospital was reviewed. There was evidence that robust arrangements were in place to ensure that written confirmation of the patients' current medicine regime was obtained and the GP and community pharmacy were contacted as necessary. Personal medication records had been accurately written. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. Staff were familiar with the type of incidents that should be reported.

The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

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

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and six monthly thereafter.

Records of staff training in relation to medicines management were available for inspection.

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 regarding the management of medicines.

We can conclude that overall the patients were being administered their medicines as prescribed. No new areas for improvement were identified.

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

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	3*	1*

* the total number of areas for improvement includes four which have been carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mrs Una McTaggart, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
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	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 21 (5) (d) (i) **Stated:** First time **To be completed by:** With immediate effect (21 September 2021)	The registered person shall ensure a robust system is in place to regularly monitor staff registration with NISCC within the required time frame.
	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 12 (1) **Stated:** First time **To be completed by:** With immediate effect (21 September 2021)	The registered person shall ensure the following in regards to the repositioning of patients: • that patients are repositioned in keeping with their prescribed care • that repositioning records are accurately and comprehensively maintained at all times • pressure relieving mattresses are effectively managed in keeping with the assessed needs of patients.
	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 Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 21 October 2021	The registered person shall ensure that the provision of activities in the home is reviewed to ensure a contemporaneous record of activities delivered, patient engagement and participation is retained.
	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

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