Inspection Report

14 November 2023

Chester

Type of service: Nursing Home
Address: 27-29 Chester Avenue, Whitehead, BT38 9QQ
Telephone number: 028 9335 3060

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Electus Healthcare 2 Ltd **Responsible Individual:** Mr Ed Coyle	**Registered Manager:** Mrs Ervina Sudjono-Hamill, not registered
Person in charge at the time of inspection: Mrs Folayemi Adewale, Nurse in charge	**Number of registered places:** 43 Including a maximum of ten patients in category NH-PH. The home is approved to provide residential care for one named resident in category RC-DE. The home is also approved to provide care on a day basis to three persons.
Categories of care: Nursing (NH): DE – dementia PH – physical disability other than sensory impairment	**Number of patients accommodated in the nursing home on the day of this inspection:** 28
Brief description of the accommodation/how the service operates: Chester is a nursing home registered to provide nursing care for up to 43 patients. Patient bedrooms are located over three floors. Patients have access to communal lounges, dining room and garden space.	

2.0 Inspection summary

An unannounced inspection took place on 14 November 2023, from 9.50am to 2.05pm and 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.

The areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection.

As a result of this inspection two new areas for improvement were identified in relation to the management of medicines. These are detailed in the quality improvement plan and include

the storage arrangements for medicines and verifying handwritten additions to medication administration records.

Whilst areas for improvement were identified, it was concluded most medicine records and medicine related care plans were well maintained; minor discrepancies were highlighted for attention. There were auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed.

RQIA would like to thank the 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 two nurses on duty. They expressed satisfaction with how the home was managed and said that they had the appropriate training to look after patients and meet their needs.

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

Feedback methods included a staff poster and paper questionnaires which were provided 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 responses 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 18 May 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** First 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 • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene.	**Carried forward to the next inspection**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		
Area for improvement 1 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure that personal care records are accurately maintained.	**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 46 **Stated:** First time	The registered person shall ensure that the environment in the home is managed to minimise the risk and spread of infection. This area for improvement specifically related to the cleaning and storage of patient equipment, environmental cleaning,	**Carried forward to the next inspection**

	waste management and management of storage space within the home.	
	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 11 **Stated:** First time	The registered person shall ensure activities are planned and delivered to provide structure to the patient's day. The activity planner would be displayed in a suitable format to meet the needs of all the patients. A contemporaneous record of activities delivered must be 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.	
Area for improvement 4 **Ref:** Standard 4.1 **Stated:** First time	The registered person shall ensure that the home's current audit processes are effective.	**Carried forward to the next inspection**
	Medicine management audits were reviewed and advice was provided on their completion. It was agreed that areas for improvement and discussion highlighted in this report would be included in audit procedures (see sections 5.2.3 and 5.2.5). **Action required to ensure compliance with this standard was not fully 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 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 state that they were accurate.

Copies of patients' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets 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. Directions for use were recorded on 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 of factors that this change may be associated with. Records included the reason for and outcome of administration.

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. Two care plans did not reflect the most recent dose change in pain medication and were highlighted for attention.

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.

The management of thickening agents was reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration, which included the recommended consistency level as appropriate, were maintained. One personal medication record needed to be updated with a recent change in the recommended consistency level, this was highlighted for attention. The care plan had been updated and staff were aware of the change.

Care plans were in place when patients required insulin to manage their diabetes.

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

Medicine 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 medicine storage areas were observed to be locked to prevent any unauthorised access when not in use. They were clean, tidy and organised so that medicines belonging to each patient could be easily located. However, for one of three medicine trolleys stored in the dining room/lounge, the method of tethering the trolley for security purposes was broken and the lock on one cupboard containing external medicines was broken. Signage indicating that oxygen cylinders were stored in the treatment room was not in place. These storage issues must be addressed to ensure the safe and secure storage of medicines. An area for improvement was identified.

The temperature of medicines storage areas was monitored and recorded. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were highlighted for monitoring. The records were filed once completed. However, handwritten entries had not routinely been verified by a second nurse, this is necessary to ensure accuracy. An area for improvement was identified.

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 mostly satisfactory arrangements in place for the management of controlled drugs. Stock balances of controlled drugs should be reconciled by the two nurses involved and a record maintained, on each occasion when responsibility is transferred. The second signature was missing in a small number of handover records and this was highlighted for attention. Nurses stated that a stock reconciliation check did take place on every occasion in line with expected practice.

Management and staff audited medicines administration within the home. A range of audits were carried out. The date of opening was recorded on medicines so that they could be easily audited.

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 or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. 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.

Nurses were familiar with the type of incidents that should be reported. There was evidence that the incidents reported to RQIA since the last inspection had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that medicines were being administered as prescribed. One discrepancy in a liquid medicine was highlighted for ongoing monitoring. It was agreed that the areas for improvement and those highlighted for discussion in this report, would be reviewed within audit procedures.

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. Competency was assessed following induction and then annually. 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, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	1*	6*

* The total number of areas for improvement includes five that have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Folayemi Adewale, Nurse in Charge, on 14 November 2023, and with Mrs Vera Ribeiro, Quality Manager, by telephone on 15 November 2023, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
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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

Action required to ensure compliance with Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** From the date of the inspection onwards (18 May 2023)	The registered person shall ensure that personal care records are accurately maintained. **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 46 **Stated:** First time **To be completed by:** Immediate action required (18 May 2023)	The registered person shall ensure that the environment in the home is managed to minimise the risk and spread of infection. This area for improvement specifically related to the cleaning and storage of patient equipment, environmental cleaning, waste management and management of storage space within the home. **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 11 **Stated:** First time **To be completed by:** From the date of the inspection onwards (18 May 2023)	The registered person shall ensure activities are planned and delivered to provide structure to the patient's day. The activity planner would be displayed in a suitable format to meet the needs of all the patients. A contemporaneous record of activities delivered must be 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
Area for improvement 4 **Ref:** Standard 4.1 **Stated:** First time **To be completed by:** Immediate action required (18 May 2023)	The registered person shall ensure that the home's current audit processes are effective. **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 30 **Stated:** First time **To be completed by:** With immediate effect (14 November 2023)	The registered person shall ensure that all medicines are safely and securely stored as detailed in the report. Ref: 5.2.2
	Response by registered person detailing the actions taken: / Treatment room locks are now functional)
Area for improvement 6 **Ref:** Standard 29 **Stated:** First time **To be completed by:** With immediate effect (14 November 2023)	The registered person shall ensure that prescription details handwritten onto medication administration records are verified and signed by two nurses/designated members of staff. Ref: 5.2.3
	Response by registered person detailing the actions taken: Discussed with RGNS issue identified on inspection, and handwritten prescriptions are being monitored by Registered Manager. No further issues have been identified. This is reviewed each monthly audit.

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