The Regulation and Quality Improvement Authority

Inspection Report

25 January 2022

Burleigh Hill House

Type of service: Nursing Home
Address: 79 North Road, Carrickfergus, BT38 7QZ
Telephone number: 028 9336 5652

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:	Registered Manager:
Organisation/Registered Provider: MD Healthcare Ltd **Responsible Individual :** Mrs Lesley Catherine Megarity	**Registered Manager:** Mrs Emeliza Insauriga **Date registered:** 28 October 2016
Person in charge at the time of inspection: Mrs Emeliza Insauriga	**Number of registered places:** 35 The total number of registered beds will decrease to 33 once an identified nursing patient is no longer accommodated in room 44. Category NH-LD for 1 identified patient only.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment LD – learning disability PH(E) - physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 24
Brief description of the accommodation/how the service operates: This is a nursing home that provides care for up to 35 patients. A residential care home is located in the same building. The manager for the nursing home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 25 January 2022 from 10.50am to 3.55pm. This was completed by a pharmacist inspector.

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

Overall, review of medicines management found that arrangements were in place to ensure the safe management of medicines and patients were administered their medicines as prescribed. Most of the medicine records and care plans were well maintained. There were processes in place to ensure that staff were trained and competent to manage medicines and a variety of medicine related audits were completed. One new area for improvement was identified regarding the management of eye preparations. The three areas for improvement stated at the last care inspection had been addressed.

Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team with respect to medicines management.

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. 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. The patients were observed to be comfortable and relaxed in their surroundings.

Staff interactions with the patients were warm, friendly and supportive. It was evident that they were familiar with the patients, their likes and dislikes.

The inspector met with nursing staff, the deputy manager and the manager. Nurses were knowledgeable about the patients' medicines. They expressed satisfaction with their work, their training and the management of the home.

All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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 last inspection?

Areas for improvement from the last care inspection on 28 October 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 21 **Stated:** First time	The registered person shall ensure that recruitment records contain evidence of an Enhanced Access NI check. Additionally, one of the two references required should be sought from the present or most recent employer, this includes agency employment. **Action taken as confirmed during the inspection**: Following the last inspection, the manager had addressed the deficits in these records. There had been no new staff since the last inspection. Given the action taken and assurances provided for future recruitment, this area for improvement has been assessed as met.	**Met**
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure that the recommended consistency of diet and fluids is recorded on the patients' food and fluid intake booklets. **Action taken as confirmed during the inspection**: Three patient's care booklets were examined. Each of these included details of the prescribed consistency level of food and fluids. Systems were in place to monitor these each month and ensure any changes were shared with staff. This information was also recorded on the daily handover sheets.	**Met**

<table>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 4.9

Stated: First time</td><td>The registered person shall ensure that night duty staff accurately and contemporaneously record patients' fluid intake.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Management advised that new fluid intake sheets had been developed to include printed times for 24 hours. There was evidence that some patients were administered fluids if the patient was awake during the night.</td></tr>
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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 check 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.

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.

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.

Review of the management of distressed reactions indicated that nurses 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. Medicine directions were clearly recorded on the personal medication records. Care plans directing the use of these medicines were in place, but one required updating; this was addressed at the inspection. The reason for and outcome of administration were recorded.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing. 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. A review of the management of thickening agents indicated that 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 and included the current dosage regime. One care plan needed updating with a recent change in dose and this was addressed at the inspection.

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. Temperatures of the medicine rooms and medicines refrigerator were monitored and recorded to ensure that medicines were stored at the correct temperature. The medicine cupboards were tidy and organised so that medicines belonging to each patient could be easily located.

In relation to medicines which have a limited shelf life once opened, for example, insulin and eye preparations, it was noted that one insulin pen device had expired. Not all eye preparations included the date of opening. This should be recorded to assist with audit and replacement once expiry is reached. See Section 5.2.3.

Satisfactory arrangements were in place for the safe disposal of medicines. However, a number of discontinued medicines remained in the medicines refrigerator; these were removed and disposed of at the inspection. Staff advised that this had been an oversight and going forward, would be closely monitored.

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.

The administration of medicines is completed on pre-printed medicine administration records (MARs). Handwritten entries had been signed by two nurses to ensure accuracy. Review of a sample of these records indicated that most had been well maintained. Systems were in place to ensure completed records were filed in a timely manner. However, the audits completed at the inspection indicated that two eye preparations were not being administered as prescribed. As the date of opening was not recorded on all eye drops, the audits on these medicines could not be concluded. An area for improvement was identified.

To monitor the administration of medicines prescribed on a "when required" basis, for example, analgesics, laxatives and medicines for distressed reactions, separate record sheets were in place and included a running stock balance of the medicine, the reason for and outcome of administration. This is good practice.

In relation to insulin administration, details of the patient's blood glucose readings and the dose administered were clearly recorded. Nurses were reminded that the site of administration should also be recorded. The manager agreed to review this with staff.

Where a patient requires their medicines to be crushed prior to administration, details were clearly recorded on the medicine administration records and medicine labels.

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 appropriately recorded in the controlled drug record books.

There were arrangements in place for staff and management to audit medicines at daily and monthly intervals. The need to include eye preparations was discussed.

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 admission process for patients new to the home or returning to the home after receiving hospital care was reviewed. Robust systems were in place to ensure that written confirmation of the patient's current medicine regime was obtained. This was shared with the patient's community pharmacist. Two staff were involved in the updating of the personal medication records and handwritten entries on the medication administration records.

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. Management and staff were familiar with the type of incidents that should be reported. There was evidence that medicine related 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. Policies and procedures should be up to date and readily available for staff.

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

One new area for improvement has been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, April 2015.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The inspection findings and details of the Quality Improvement Plan were discussed with Mrs Emeliza Insauriga, Registered Manager, and the deputy manager as part of the inspection process. The timescales for completion commence from the date of inspection.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with the Care Standards for Nursing Homes, April 2015</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 29

Stated: First time

To be completed by:
Immediately and ongoing</td><td>The registered person shall closely monitor the management of eye preparations to ensure these are administered as prescribed and records are accurately maintained.

Ref: 5.2.3</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Nurses have completed supervision sessions in regard to the appropriate management of eye preparations, to ensure these are administered as prescribed and that records are accurately maintained. This will be closely monitored by the Home Manager and the senior staff in the home and also through the auditing process.</td></tr>
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