The Regulation and Quality Improvement Authority

Inspection Report

24 January 2022

Camphill

Type of service: Nursing Home
Address: 62 Toome Road, Ballymena, BT42 2BU
Telephone number: 028 2565 8999

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: Four Seasons Health Care **Responsible Individual:** Mrs Natasha Southall	**Registered Manager:** Mr Vasco Alves **Date registered:** 6 November 2019
Person in charge at the time of inspection: Ms Sharon Bell (Acting Deputy Manager) until 12.00pm and Mr Vasco Alves thereafter	**Number of registered places:** 72
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years 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:** 44
Brief description of the accommodation/how the service operates: Camphill is a nursing home which provides care for up to 72 patients. The home is divided into three units. The Glendun Unit and Glenshesk Unit (currently closed) accommodate patients living with dementia and the Glenariff Unit accommodates patients who require general nursing care.	

2.0 Inspection summary

A pharmacist inspector completed an unannounced inspection on 24 January 2022, from 10.40am to 3.05pm.

This inspection focused on medicines management within the home and also assessed progress with three of the 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.

Following discussion with the aligned care inspector, it was agreed that the other areas for improvement identified at the last care inspection would be followed up at the next care inspection.

Review of medicines management found that robust arrangements were in place. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. No new areas for improvement in relation to medicines management were identified.

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.

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 reviewing a sample of medicine related records and care plans, medicines storage and the auditing systems used to ensure the safe management of medicines. Discussions were held with 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

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 acting deputy manager and the manager. Nurses spoke positively about their induction, training, the support provided and the team working in the home. They were knowledgeable about the patients' medicines.

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 inspection on 17 August 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 16 (1) (2) (b) **Stated:** Second time	The registered person shall ensure care plans are implemented and reviewed by registered nurses in consultation with the patient or patient's representative.	**Met**
	Action taken as confirmed during the inspection: A review of seven patients care files indicated that the patient's next of kin had signed a form to state they were in agreement with the care plans; the forms were dated between August 2021 and November 2021.	
Area for Improvement 2 **Ref**: Regulation 13 (7) **Stated:** Second 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. A more robust system should be in place to ensure compliance with best practice on infection prevention and control.	**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 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 an accurate record of pressure mattress settings and wound care is recorded in patients care records.	**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 12.9 **Stated:** First time	The registered person shall ensure nurses have the skills and knowledge in managing feeding techniques for patients who have swallowing difficulties.	**Met**
	Action taken as confirmed during the inspection: Following the last inspection, all staff had received training in the management of swallowing difficulties. In addition, a new IDDSI (International Dysphagia Diet Standardisation Initiative) training module had been developed; several staff had already completed this with the remainder due to complete within the month. The patients' records which were examined indicated that the relevant care plans were in place and included details of the prescribed food and fluid levels.	
Area for improvement 3 **Ref:** Standard 44 **Stated:** First time	The registered person shall ensure that the premises and equipment are well maintained and fit for purpose including a bathroom which was out of order, hot water provision, a torn chair, a number of chipped radiator covers and door frames, a damaged sink surround and chest of drawers and the chipped assisted bath.	**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 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 samples of personal medication records examined 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 confirm that they were accurate. Obsolete records were securely archived. On occasion, the handwriting was difficult to read. The manager discussed with staff during the inspection and assured that this would be closely monitored.

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. Staff 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 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.

Review of the management of distressed reactions indicated that staff 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 available; one care plan required further detail. The manager confirmed that this had been addressed immediately after 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 a speech and language assessment report and care plan were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

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 rooms were securely locked to prevent any unauthorised access. The cupboards and medicine trolleys were tidy and organised so that medicines belonging to each patient could be easily located. The lock on one medicine trolley was broken and had been reported for repair or replacement. An alternate locking mechanism was put in place immediately after the inspection. Temperatures of the medicine storage areas including the medicines refrigerators were monitored and recorded to ensure medicines were stored at the correct temperature.

There were satisfactory arrangements in place for the safe disposal of medicines, including controlled drugs.

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 record of the administration of medicines was completed on pre-printed medicine administration records (MARs). A sample of these records was reviewed; they were found to have been fully and accurately maintained. The completed records were filed in a timely manner and were readily retrievable for inspection.

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 a controlled drug record book.

Occasionally, a patient may have their medicines administered in food/drinks to assist administration. This had been discussed with the patient's GP and community pharmacist to ensure the medicines were safely administered. Details were recorded on the MARs and medicine labels and care plans.

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

Management and staff audited medicine administration on a regular basis within the home. A specific programme of audits per patient per week was in place. The date of opening was recorded on all medicines so that they could be easily audited and a running stock balance was maintained. These are areas of good practice.

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 the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

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

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

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

	Regulations	Standards
Total number of Areas for Improvement	1*	2*

* Three areas for improvement are carried forward for review at the next inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for Improvement 2 **Ref**: Regulation 13 (7) **Stated:** Second time **To be completed by:** With immediate effect (17 August 2021)	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. A more robust system should be in place to ensure compliance with best practice on infection prevention and control. **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 4.9 **Stated:** First time **To be completed by:** With immediate effect (17 August 2021)	The registered person shall ensure that an accurate record of pressure mattress settings and wound care is recorded in patients care records. **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 44 **Stated:** First time **To be completed by:** 30 September 2021	The registered person shall ensure that the premises and equipment are well maintained and fit for purpose including a bathroom which was out of order, hot water provision, a torn chair, a number of chipped radiator covers and door frames, a damaged sink surround and chest of drawers and the chipped assisted bath. **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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