The Regulation and Quality Improvement Authority

Inspection Report

24 October 2023

Camphill Care Home

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: Beaumont Care Home Limited **Responsible Individual** Mrs Ruth Burrows	**Registered Manager:** Mr Vasco Alves **Date registered:** 6 November 2019
Person in charge at the time of inspection: Ms Gemma Boyd, Deputy Manager	**Number of registered places:** 72 Including a maximum of 42 patients in category NH-DE accommodated within the dementia wing.
Categories of care: Nursing (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	**Number of patients accommodated in the nursing home on the day of this inspection:** 56
Brief description of the accommodation/how the service operates: Camphill Care Home is a nursing home registered to provide nursing care for up to 72 patients. The home is divided into three units, the Glendun Unit which provides care for people living with dementia, the Glenariff Unit which provides general nursing care and the Glenshesk Unit which is currently not in use. There are communal dining and lounge areas in all units. There is a mature garden and seating area for patient use.	

2.0 Inspection summary

An unannounced medicines management inspection took place on 24 October 2023 from 9.45am to 2.35pm. This was completed by two pharmacist inspectors and 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.

Five of the six areas for improvement identified at the last care inspection on 15 June 2023 will be followed up at the next care inspection. One area for improvement from the last care inspection was reviewed and assessed as met.

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 ensuring that medicine records correlate and reflect the prescriber's most recent instructions and the accurate completion of handwritten medication administration records.

Whilst areas for improvement were identified, it was concluded that most medicine records and medicine related care plans were well maintained. 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 inspectors 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 inspectors met with four nurses and the deputy manager.

Staff 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 well.

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 15 June 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:** Second time	The responsible individual shall ensure the deficits in infection prevention and control practices identified in the report are addressed.	**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.	
Area for improvement 2 **Ref:** Regulation 13 (4)(b) **Stated:** First time	The responsible individual shall ensure that the medicine which is prescribed is administered as prescribed to the person for whom it was prescribed.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was reviewed and assessed as met.	
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 41 **Stated:** Second time	The responsible individual shall ensure the hours worked by the manager and the full name and designation of staff is included on the staff duty rota.	**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 responsible individual shall ensure that training in moving and handling of patients is embedded into practice and monitored on a regular basis.	**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 12 **Stated:** First time	The responsible individual shall ensure that the menu is displayed in suitable format and displays the correct meals to be served each day.	**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 44 **Stated:** First time	The responsible individual shall ensure that the areas in the home which were identified as requiring maintenance or repair are addressed.	**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. Although a second member of staff routinely checked and signed the personal medication records when they were written and updated to state that they were accurate, which is good

practice, a small number of discrepancies with printed medication administration records and current prescribed instructions were observed which have the potential to impact on the patient. Records must correlate and reflect the prescriber's most recent instructions. An area for improvement was identified.

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 the factors that this change may be associated with. Records usually included the reason for and outcome of administration. Nurses were reminded that this must be recorded on every occasion.

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.

A care plan was in place for potential anaphylaxis. It was agreed that the use of prescribed adrenaline would be added, to include relevant details including the location of the emergency medication.

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 and food supplements 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 change in recommended consistency level prescribed the day before the inspection, this was addressed immediately. 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. The temperature of medicines storage areas was monitored and recorded. Medicine refrigerators and controlled drugs cabinets were available for use as needed. One medicine refrigerator thermometer needed to be examined/replaced due to inaccurate temperature readings and alarms. The deputy manager stated that this had been reported and would be addressed promptly.

It was agreed that inhaler spacer devices would be labelled and stored covered for infection prevention and control purposes.

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. Those that had been printed were found to have been accurately completed. The records were filed once completed. However, a significant number of handwritten administration records did not include the start/full date of administration, which renders the record obsolete once filed. Records must be maintained as to ensure there is a clear audit trail. 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. Balances for controlled drugs in the nurse handover book in one unit, had been completed in advance by one nurse for stock balance checks due to take place at shift handover. This was highlighted and the deputy manager stated that nurses would be reminded of the expected practice. It was acknowledged that these medicines had been administered as prescribed and the controlled drug record book had been accurately maintained.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only

occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Consent was recorded and care plans were in place when this practice occurred.

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

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.

Management and nurses 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 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 exception 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 Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	2*	5*

* 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 Ms Gemma Boyd, Deputy 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 The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** Second time **To be completed by:** With immediate effect (15 June 2023)	The responsible individual shall ensure the deficits in infection prevention and control practices identified in the report are addressed. **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 13 (4) **Stated:** First time **To be completed by:** With immediate effect (24 October 2023)	The registered person shall ensure that personal medication records and medication administration records correlate and reflect the prescriber's most recent instructions. Ref: 5.2.1 **Response by registered person detailing the actions taken:** The deficits in the correlation between personal medication records and medication administration records were discussed with the nursing team and addressed post inspection . This will continue to be reviewed as part of the monthly medication audit. This will also be monitored as part of the Regulation 29 visit.
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 41 **Stated:** Second time **To be completed by:** With immediate effect (15 June 2023)	The responsible individual shall ensure the hours worked by the manager and the full name and designation of staff is included on the staff duty rota. **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

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

Ref: Standard 39

Stated: First time

To be completed by:
With immediate effect
(15 June 2023)</td><td>The responsible individual shall ensure that training in moving and handling of patients is embedded into practice and monitored on a regular basis.</td></tr>
<tr><td>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</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 12

Stated: First time

To be completed by:
30 June 2023</td><td>The responsible individual shall ensure that the menu is displayed in suitable format and displays the correct meals to be served each day.</td></tr>
<tr><td>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</td></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 44

Stated: First time

To be completed by:
31 July 2023</td><td>The responsible individual shall ensure that the areas in the home which were identified as requiring maintenance or repair are addressed.</td></tr>
<tr><td>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</td></tr>
<tr><td rowspan="2">Area for improvement 5

Ref: Standard 29

Stated: First time

To be completed by:
With immediate effect
(24 October 2023)</td><td>The registered person shall ensure that handwritten medicine administration records include the start/full date of administration to facilitate a clear audit trail.

Ref: 5.2.3</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The deficits in the handwritten medicine administration records were discussed with the nursing team and addressed post inspection . This will continue to be reviewed as part of the monthly medication audit.This will also be monitored as part of the Regulation 29 visit.</td></tr>
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