

Inspection Report

Name of Service:	Collegeland Nursing Home
Provider:	Roughan Care Ltd
Date of Inspection:	29 October 2024

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

1.0 Service information

Organisation:	Roughan Care Ltd
Responsible Individual:	Mr Patrick Anthony McAvoy
Registered Manager:	Mrs Kathleen McBride
Service Profile: Collegeland Nursing Home is a registered nursing home which provides nursing care for up to 34 patients. The accommodation is located over ground floor level and patients have access to an enclosed courtyard area and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 29 October 2024, from 10.10 am to 2.30 pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and if the service is well led in relation to medicines management.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. 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. However, improvements were necessary in relation to medicine records and medicine related care plans.

Whilst areas for improvement were identified, there was evidence that patients were being administered their medicines as prescribed.

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.0.

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection the RQIA inspector will seek to speak with patients, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home.

3.2 What people told us about the service and their quality of life

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

No completed questionnaires or responses to the staff survey were received following the inspection.

3.3 Inspection findings

3.3.1 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 a GP, a 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.

Personal medication records were reviewed; some records were not up to date with the most recent prescription. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. A number of discrepancies were highlighted to nurses for immediate corrective action and on-going vigilance. An area for improvement was identified.

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

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.

The management of thickening agents, insulin and administration of medicines via the enteral route was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed. One in use insulin pen was not individually labelled and the date of opening was not recorded to facilitate audit and disposal at expiry. This was highlighted to the nursing staff for immediate correction and ongoing vigilance.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care records are in place to direct staff 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.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Staff were familiar with their patients and knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. Care plans directing the use of these medicines were in place for some but not all patients. Records of administration did not consistently include the reason for and outcome of each administration. An area for improvement was identified.

3.3.2 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.

Records reviewed 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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage areas was monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

Satisfactory arrangements were in place for the safe disposal of medicines.

3.3.3 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 verification signatures were brought to the attention of the manager for ongoing monitoring. Records were filed once completed and were readily retrievable for audit/review.

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 satisfactory arrangements in place for the management of controlled drugs.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed/ action plans had been implemented and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

3.3.4 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 at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 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 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 the learning shared with staff in order to prevent a recurrence.

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

3.3.6 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. Ongoing review was monitored through supervision with staff and at annual appraisal. Medicines management policies and procedures were in place.

4.0 Quality Improvement Plan/Areas for Improvement

Two new areas for improvement have been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Kathleen McBride, Registered 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 Care Standards for Nursing Homes, December 2022	
Area for improvement 1 Ref: Standard 18 Stated: First time To be completed by: From the date of inspection (29 October 2024)	The registered person shall ensure that care plans are in place with sufficient detail to direct care when medicines are prescribed for the management of distressed reactions. The reason for and outcome of administration should be recorded. Ref: 3.3.1
	Response by registered person detailing the actions taken: Manager has audited care plans for distressed reactions and action plans have been completed to address deficits. Manager will continue to audit care plans. All registered Nurses have been reminded that reasons for and the outcome of administration must be recorded. These records will also be reviewed as a part of the audit process.
Area for improvement 2 Ref: Standard 29 Stated: First time To be completed by: From the date of inspection (29 October 2024)	The registered person shall ensure that personal medication records are accurately maintained and verified by two members of staff to ensure accuracy. Ref: 3.3.1
	Response by registered person detailing the actions taken: Outcome of inspection has been shared with Registered Nurses. Registered Nurses have been reminded of their responsibilities in ensuring that 2 members of staff must verify the records to ensure accuracy thus reducing risk of errors. Manager will review these records as part of the audit process.

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