Inspection Report

18 July 2023

Iveagh House Private Nursing Home

Type of service: Nursing Home
Address: 62 Castlewellan Road, Banbridge, BT32 4JD
Telephone number: 028 4062 8055

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: Spa Nursing Homes Ltd **Responsible Individual:** Mr Christopher Philip Arnold	**Registered Manager:** Miss Louise Riley **Date registered:** 26 April 2023
Person in charge at the time of inspection: Miss Louise Riley	**Number of registered places:** 33
Categories of care: Nursing (NH): I – old age not falling within any other category	**Number of patients accommodated in the nursing home on the day of this inspection:** 29
Brief description of the accommodation/how the service operates: Iveagh House Private Nursing Home is a registered nursing home which provides nursing care for up to 33 patients. Patients' bedrooms are located over three floors and patients have access to communal dining and lounge areas.	

2.0 Inspection summary

An unannounced inspection took place on 18 July 2023, from 10.30am to 3.15pm. This was completed by a pharmacist inspector 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.

The areas for improvement identified at the last care inspection have been carried forward for follow up at the next care inspection.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan (QIP) and include the maintenance of personal medication records, ensuring patients have a supply of their prescribed medicines and controlled drug record keeping.

Whilst areas for improvement were identified, it was concluded that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed. Medicines were stored safely and securely and staff with responsibility for medicines management had received relevant training. The manager agreed to share the findings of this inspection with staff in order to drive and sustain improvements.

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 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 care staff, nursing staff and the manager. Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

Staff expressed satisfaction with how the home was managed and stated there was good teamwork. They also said that they had the appropriate training to look after patients and meet their needs.

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 the last inspection?

Areas for improvement from the last inspection on 21 April 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time	The registered person shall ensure that neurological observations are conducted and recorded in line with best practice guidance following any fall resulting in a head injury / potential head injury.	**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 12 (1) (a) and (b) **Stated:** First time	The registered person shall ensure that registered nurses maintain an oversight of supplementary care records to make sure that the appropriate care has been delivered. Any actions taken as a result of review should be clearly documented within the daily evaluation notes.	**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 3 **Ref:** Regulation 14 (2) (a) and (c) **Stated:** First time	The registered person shall ensure that radiators in the home are maintained at a low heat, otherwise, covered to minimise the risk of accidental burns.	**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
Area for improvement 1 **Ref:** Standard 4 Criteria (9) **Stated:** First time	The registered person shall ensure that records of repositioning are recorded contemporaneously and include: • the position the patient was repositioned to • the frequency of repositioning • evidence of skin checks at time of repositioning • signatures of any staff involved in the repositioning.	**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 44 **Stated:** First time	The registered person shall ensure that all freestanding wardrobes in the home are securely fastened to the wall for safety.	**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 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.

It was identified that the personal medication records were not up to date with the most recent prescription and some were incomplete. Antibiotic medicines had not been recorded as discontinued when the course had been completed. On occasions when medicines had been held pending review by the prescriber, this had not been accurately documented in the records. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. 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.

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.

The management of medicines prescribed on a "when required" basis for distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome of each administration.

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.

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. All staff should have the necessary training to ensure that they can meet the needs of the patient.

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 were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route. However, it was identified that one dose of a nutritional supplement had been missed on the morning of the inspection as there was no stock. Patients must have a continuous supply of their prescribed medicines, including nutritional supplements, as missed doses or late administrations can impact upon their health or well-being. An area for improvement was identified.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside the recommended range.

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 the large majority of medicines were available for administration when patients required them. However, audits completed by the inspector identified a total of four medicines had been out of stock in recent weeks which resulted in missed doses. This was highlighted to the manager on the day of the inspection who provided assurances that the ordering process for medicines would be reviewed to ensure medicines were ordered and obtained in a timely manner. As per Section 5.2.1, an area for improvement in relation to ensuring patients have a continuous supply of their prescribed medicines was identified.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory 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 brought to the attention of the manager for ongoing monitoring. The records were filed once completed and readily retrievable for 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 were recorded in the controlled drug record book. Review of the controlled drug record book identified one discrepancy in the quantity of a Schedule 2 Controlled Drug. The discrepancy was highlighted to the manager on the day of the inspection for investigation and review. An incident report detailing the outcome of the investigation and measures implemented to prevent a recurrence was submitted to RQIA on 27 July 2023. The controlled drug record book must be accurately maintained at all times. An area for improvement was identified.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed by the inspector identified that despite a small number of missed doses due to out of stock medicines; the large majority of medicines were administered as prescribed. The manager provided assurances that the findings of this inspection would be included in the audit process moving forward to ensure shortcomings are addressed.

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

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.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

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, 2015.

	Regulations	Standards
Total number of Areas for Improvement	5*	3*

* 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 Miss Louise Riley, 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time **To be completed by:** With immediate effect (21 April 2023)	The registered person shall ensure that neurological observations are conducted and recorded in line with best practice guidance following any fall resulting in a head injury / potential head injury. **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 12 (1) (a) and (b) **Stated:** First time **To be completed by:** 21 May 2023	The registered person shall ensure that registered nurses maintain an oversight of supplementary care records to make sure that the appropriate care has been delivered. Any actions taken as a result of review should be clearly documented within the daily evaluation notes. **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 3 **Ref:** Regulation 14 (2) (a) and (c) **Stated:** First time **To be completed by:** Immediate action required (21 April 2023)	The registered person shall ensure that radiators in the home are maintained at a low heat, otherwise, covered to minimise the risk of accidental burns. **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 4 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** Ongoing from the date of inspection (18 July 2023)	The registered person shall ensure patients have a continuous supply of their prescribed medicines. Ref: 5.2.1 & 5.2.2 **Response by registered person detailing the actions taken**: The Registered Manager has addressed with nursing staff the importance of ensuring all residents have a continuous supply of medication. Stock balances of all drugs are underway to ensure timely ordering.

Area for improvement 5 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Ongoing from the date of inspection (18 July 2023)	The registered person shall ensure that the controlled drug record book is fully and accurately maintained. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Registered Manager is monitoring completion of the controlled drug book to ensure it is fully and accurately maintained.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 4 Criteria (9) **Stated:** First time **To be completed by:** Immediate action required (21 April 2023)	The registered person shall ensure that records of repositioning are recorded contemporaneously and include: • the position the patient was repositioned to • the frequency of repositioning • evidence of skin checks at time of repositioning • signatures of any staff involved in the repositioning.
	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 44 **Stated:** First time **To be completed by:** 21 May 2023	The registered person shall ensure that all freestanding wardrobes in the home are securely fastened to the wall for safety.
	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 29 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (18 July 2023)	The responsible person shall ensure that personal medication records are fully and accurately completed and are reflective of the patient's currently prescribed medicines. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Registered Manager has had all kardex rewritten to ensure that they are all accurately completed and are reflective of the current prescribed medicines. This is an area that the Registered Manager continues to monitor. Medication Training has been arranged for nursing staff.

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