Inspection Report
1 March 2021

Mountvale

Type of Service: Nursing Home
Address: Brewery Lane, Meeting Street, Dromore BT25 1AH
Tel No: 028 9269 9480
Inspector: Judith Taylor

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home which is registered to provide care for up to 51 patients.

2.0 Service details

Organisation/Registered Provider: Mountvale Private Nursing Home Ltd **Responsible Individual:** Mr William Trevor Gage	**Registered Manager and date registered:** Miss Heather Joan Maxwell 13 January 2020
Person in charge at the time of inspection: Miss Heather Maxwell	**Number of registered places:** 51 There shall be a maximum of one named resident receiving residential care in category RC-I.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years	**Total number of patients in the nursing home on the day of this inspection:** 35

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 1 March 2021. Following a risk assessment and to reduce the risk to patients during the pandemic outbreak, this inspection was carried out remotely.

It was completed following a review of information requested and submitted to RQIA on 15 February 2021. This information included the completion of a self-assessment specific to medicines management in the home. Feedback was discussed with the manager on 1 March 2021.

We focused on medicines management within the home and also assessed the progress made regarding the area for improvement identified at the last inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to patients' relatives by telephone
- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- completed medicines related self-assessment
- medicine receipt and disposal
- care plans related to medicines management
- governance and audit arrangements for medicines management
- medicine related incidents
- staff training and competency regarding medicines management

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	1

The area for improvement and details of the Quality Improvement Plan (QIP) were discussed with Miss Heather Maxwell, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection. Enforcement action did not result from the findings of this inspection.

5.0 What has this home done to meet any areas for improvement identified at the last inspection on 21 October 2019?

Areas for improvement from the last inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that care plans for the management of pain are completed for patients requiring regular pain relief.	**Met**
	Action taken as confirmed during the inspection: There was evidence that pain management care plans were maintained for patients prescribed medicine(s) to manage pain. A pain assessment tool was in use as needed to monitor the patient's pain.	

6.0 What people told us about this home?

As part of the remote inspection process, we were provided with contact details of five patients' relatives. We were able to speak with four relatives. The comments were very positive and complimentary regarding the care provision and the staff team.

Comments made included:

- "Happy with the care and content that xxx is very comfortable in the home."
- "We are well informed about things."
- "Couldn't fault the care, very happy with everything."
- "Staff are great and always let me know what's going on."
- "Extremely good, very happy with care."

Feedback methods included a poster and links to online questionnaires which were provided to the manager for staff and any patient or their family representative to complete. At the time of issuing this report, no questionnaires had been received by RQIA.

7.0 Inspection Findings

7.1 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 a GP, a pharmacist or during a hospital admission. We confirmed that patients were registered with a GP and medicines were dispensed by the community pharmacist.

A sample of patients' personal medication records was reviewed. 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 and/or hospital appointments. We found that these were well maintained. In line with best practice, a second member of staff had checked and signed these records when they were written and updated, to ensure 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.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. We reviewed a sample of medicine related care plans, for example, the management of pain, swallowing difficulty and distressed reactions. These contained the necessary information. A separate record was maintained to include the reason for and the outcome of any of these medicines prescribed on a "when required" basis. This is best practice.

7.2 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. This is assisted by accurately maintaining records of incoming and outgoing medicines.

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.

As this was a remote inspection, we did not observe the storage and disposal arrangements for medicines. These were discussed with the manager, who assured us that all medicines were stored safely and securely in the treatment rooms and medicines were clearly segregated to indicate each patient's supply.

In relation to the disposal of medicines, the current procedure should be reviewed to ensure that all medicines are disposed of in the nursing home, prior to being transferred to the clinical waste company. This was discussed with reference to RQIA guidance 'The Disposal of Medicines In Nursing Homes 2011'. An area for improvement was identified.

7.3 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.

We reviewed a sample of the administration of medicines records. Most of these had been fully and accurately completed. Reminder systems were in place to assist staff in administering medications outside of the usual medicine round times or medicines which were prescribed on a twice weekly or weekly basis. We also noted that two staff were involved in the administration of insulin and a separate insulin administration chart was in use. These are examples of good practice.

In the instances where care staff were responsible for the administration of topical medicines, the manager advised that separate records were maintained and checked for accuracy on a weekly basis. The manager also advised that these records would form part of her monthly audit.

The governance arrangements for medicines management were examined. These are processes that monitor medicine systems to ensure they are working well and that patients are being administered their medicines. They also enable identification of any deficits that may need to be addressed. Management and staff audited medicine administration on a regular basis within the home and details of these and the planned improvements were provided in the submitted documents. It was evident that audits included various medicine formulations and records. Any issues identified were addressed through an action plan and followed up at the next audit.

7.4 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, including prescribed medicines is transferred, put people at increased risk of harm when they change from one healthcare setting to another.

We reviewed the management of medicines processes for patients new to the home. There was evidence that robust procedures were in place to obtain written confirmation of the patient's medicine regime and to ensure accurate completion of the relevant medicines records.

7.5 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. An effective auditing system will assist staff in the identification of any medicine related incidents.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. 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.

7.6 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 they are supported. In addition, up to date policies and procedures should be readily available for staff.

Information about staff medicines management training and policies and procedures were provided in the documents submitted to RQIA. They indicated that policies were in place and reviewed regularly. Training and competency assessments had been completed for nursing staff and specific training regarding topical medicines and thickening agents had been provided for care staff.

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

The outcome of this inspection concluded that good systems were in place to safely manage medicines and ensure that patients were being administered their medicines as prescribed. In relation to the last QIP, the area for improvement had been addressed. One new area for improvement was identified.

We would like to thank management and patients' relatives for their assistance in contributing to this remote inspection.

9.0 Quality Improvement Plan

The area for improvement identified during this inspection is detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Miss Heather Maxwell, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

9.1 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

9.2 Actions to be taken by the home

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the arrangements for the disposal of medicines to ensure that these are in line with current guidance and standards. Ref: 7.2
To be completed by: From the date of inspection onwards	**Response by registered person detailing the actions taken:** The arrangements for the disposal of medicines has been reviewed and these are now in line with current guidance and standards. The disposal of medication policy has also reviewed to reflect the new arrangements.

Please ensure this document is completed in full and returned via the Web Portal

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