The Regulation and Quality Improvement Authority

Inspection Report

3 August 2021

Nightingale Care Home

Type of service: Nursing Home
Address: 34 Old Eglish Road, Dungannon, BT71 7PA
Telephone number: 028 8775 2666

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: Healthcare Ireland (Belfast) Limited **Responsible Individual(s):** Ms Amanda Celine Mitchell	**Registered Manager:** Ms Jennifer Willis **Date registered:** 22 January 2021
Person in charge at the time of inspection: Ms Maria Tennyson	**Number of registered places:** 35 This number includes a maximum of three patients in category NH-PH.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment MP – mental disorder excluding learning disability or dementia	**Number of patients accommodated in the nursing home on the day of this inspection:** 30
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for up to 35 patients. This home shares the same building as Nightingale Care Home residential care home.	

2.0 Inspection summary

An unannounced inspection took place on 3 August 2021, between 12.30pm and 3.45pm. The inspection was completed by a pharmacist inspector.

This inspection focused on medicines management within the home and also assessed progress with any areas for improvement identified since the last care inspection.

Good systems for the management of medicines were in place. Medicines were stored safely and securely and audits showed that patients were administered their medicines as prescribed. Medicine records had been fully and accurately completed. Audit and governance systems within the home were effective at identifying and rectifying any medicine related issues.

No new areas for improvement with regards to medicines management were identified.

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. To complete the inspection 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 were reviewed.

4.0 What people told us about the service

Staff were warm and friendly and it was evident from their interactions that they knew the patients well.

We met with the deputy manager, one nurse, the activities co-ordinator and the regional manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered 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 11 May 2021		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 17 (7)	The registered person shall ensure that robust training arrangements are in place for staff; this relates specifically to the completion of Deprivation of Liberty safeguards training.	**Met**

Stated: First time	**Action taken as confirmed during the inspection**: There was evidence that staff had received further training in the Deprivation of Liberty Safeguards which was appropriate for their role.	
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that patients' spiritual care such as religion and clergy contact details are adequately recorded.	**Met**
	Action taken as confirmed during the inspection: Details of patients' spiritual care had been collated and there was a record of clergy contact details.	
Area for Improvement 3 **Ref:** Standard 9 (5) **Stated:** First time	The registered person shall ensure the genre of music played for patients is appropriate to their personal preference.	**Met**
	Action taken as confirmed during the inspection: Staff were aware of patient preferences with regards to music genre and ensured that this was available for patients to listen to.	

No areas for improvement were identified at the last medicines management inspection on 28 November 2017.

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, during medication reviews or hospital appointments.

The personal medication records reviewed at the inspection 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 are written and updated to provide a double check that they were accurate.

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, self-administration 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 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.

The management of medicines prescribed on a “when required” basis for the management of distressed reactions was reviewed. A very small number of patients are prescribed these medicines and they were rarely used. 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. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file.

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.

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. The management of thickening agents and nutritional supplements was reviewed for two patients. Speech and language assessment reports and care plans were 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 tube. The management of medicines and nutrition via the enteral route was reviewed. 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. This is necessary to ensure that the recommended daily fluid intake is achieved.

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 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.

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.

When medicines are administered to a patient, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. The sample of these records reviewed had been fully and accurately completed. The records were filed once completed and were readily retrievable for audit and 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 are recorded in a controlled drug record book. These records had been fully and accurately completed.

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. Audits completed during the inspection showed that patients were receiving their medicines as prescribed.

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 was reviewed. Robust arrangements were in place to ensure that staff were provided with an accurate list of medicines on admission. If the patient was admitted from hospital, the list of currently prescribed medicines was shared with the patient's GP and the community pharmacist to ensure that all medicine records were up to date. The patients' personal medication records had been updated by two nurses to ensure accuracy. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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.

The small number of medicine related incidents which had been reported to RQIA since the last inspection was discussed. 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.

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.

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 Conclusion

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 all areas for improvement identified at the last care inspection had been addressed. No new areas for improvement with regards to medicines management were identified. RQIA is assured that patients were being administered their medicines as prescribed.

Based on the inspection findings and discussions held RQIA is 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 manager/management team

We would like to thank the patients and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Maria Tennyson, Deputy Manager, as part of the inspection process and can be found in the main body of the report.

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