The Regulation and Quality Improvement Authority

Inspection Report

4 July 2024

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 No 2 Ltd **Responsible Individual:** Ms Amanda Mitchell	**Registered Manager:** Miss Iulia Nicolae **Date registered:** 17 May 2024
Person in charge at the time of inspection: Miss Iulia Nicolae, Manager	**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: Nightingale Care Home is a nursing home which is registered to provide care for up to 35 patients. The home is a single storey building. All bedrooms are single occupancy. Patients have access to communal lounges, a dining room and a garden. This home shares the same building as Nightingale Residential Care Home. The manager is responsible for both services.	

2.0 Inspection summary

An unannounced inspection took place on 4 July 2024 from 10.30am to 4.10pm. The inspection 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 inspection also assessed progress with the area for improvement identified at the last care inspection.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines. Some issues in relation to the secure storage of medicines were addressed during the inspection. The majority of medicine records and medicine related

care plans were well maintained. There were effective auditing processes in place to ensure that nurses were trained and competent to manage medicines and patients were administered their medicines as prescribed. One area for improvement in relation to medication administration records was identified.

Based on the inspection findings and discussions held, RQIA are 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 management team in relation to the management of medicines.

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 the home was 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, the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with 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 one registered nurse, the deputy manager, the manager and the regional manager.

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

The staff members spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

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 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 care inspection on 8 February 2024		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered person shall ensure that all parts of the home to which patients have access are free from hazards to their safety.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was in relation to patient access to rooms which contained hot water systems. The doors to rooms that contained hot water systems were observed to be locked at the inspection. The manager and regional manager advised that all staff were aware that these rooms must be locked at all times.	

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 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.

The majority of personal medication records reviewed were accurate and up to date, a small number of anomalies were brought to the attention of the nurses for immediate review. In line with safe practice, a second nurse had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. The manager and nurses were reminded that the personal medication record should be used as part of the medication administration process and hence should be filed adjacent to the pre-printed medication administration records (MARs). Assurances were provided that this would be addressed following the inspection and reviewed through the home's audit processes.

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 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. Nurses 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, infection or constipation. Directions for use were clearly recorded on the personal medication records. Care plans directing the use of these medicines were available. For one patient the medicines were being administered regularly; this had been referred to their GP for review. There had been no recent administrations for other patients.

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.

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 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.

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

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 supplements, water and medicines were maintained. Nurses on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

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 locked to prevent any unauthorised access. However, the code to the treatment room door had been written adjacent to the digital lock; this was removed during the inspection. With the exception of nutritional supplements storage was organised so that medicines belonging to each patient could be easily located. It was agreed that the storage of nutritional supplements would be addressed following the inspection and monitored through the audit process.

Satisfactory systems were in place to ensure that medicines were stored at the correct temperature.

Records of disposal did not include the patient's name. This was discussed with the management team who advised that the company had recently purchased new disposal books which did not include a section to record the patient's name. The regional manager agreed to ensure that this was addressed throughout the company. The security of medicines awaiting disposal was also discussed for review.

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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The majority of the records had been completed in a satisfactory manner. However, some records were difficult to review due to the standard of the photocopy i.e. staff were signing on a black background. In addition, it was difficult to see the difference between codes for non-administration and signatures for administration. The registered person shall ensure that medication administration records are clearly maintained. Systems should be reviewed to ensure that codes used for non-administration can be distinguished from signatures for administration. 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 records of receipt, administration and disposal of controlled drugs were maintained to the required standard in a controlled drug record book.

Management and staff audited medicine administration on a regular basis within the home. In addition, running stock balances were maintained for all medicines. The majority of audits completed at the inspection indicated that medicines were administered as prescribed. A small number of discrepancies were discussed for ongoing review

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 patients new to the home or returning from hospital. Written confirmation of the patients' medicine regimes was obtained at or prior to admission and details shared with their general practitioners and community pharmacy. The medicine records reviewed at the inspection had been accurately completed and there was evidence that medicines were administered as prescribed.

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 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 learning shared with staff in order to prevent a recurrence.

It was agreed that the findings of this inspection in relation to record keeping and storage would be closely monitored through the audit process to ensure that the actions agreed at the inspection had been implemented and the improvements sustained.

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 they are supported. Policies and procedures should be up to date and readily available for staff.

Nurses in the home had received a structured induction which included medicines management. Competency had been assessed following induction and annually thereafter. Records of induction, annual update training and competency assessments were available for inspection.

The manager advised that the findings of this inspection would be shared with all nurses for ongoing improvement.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	1	0

The area for improvement and details of the Quality Improvement Plan was discussed with Miss Iulia Nicolae, Registered Manager, and Mrs Karen Agnew, Regional Manager, as part of the inspection process. The timescale for completion commences 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 (4) **Stated:** First time **To be completed by:** From the date of inspection (4 July 2024)	The registered person shall ensure that medication administration records are clearly maintained. Ref 5.2.3
	Response by registered person detailing the actions taken: The providing chemist no longer provides blank pre printed Mar sheets which staff can use to enter medications prescribed out of normal 28 day cycle . They have however now provided the home with a printable PDF document which the staff can use rather than photocopies . Staff have been advised that when using codes on the Mar they are to circle the entry to differeniate between the code and a possible signature. Nursing staff to use initials only for Mars in order the audit to be more accurate and identification to be done easier in case of an error.

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