Inspection Report

27 September 2022

Sanville

Type of service: Nursing Home
Address: 17b Annagher Road, Coalisland, Dungannon, BT71 4NE
Telephone number: 028 8774 8005

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: Sanville **Responsible Individuals:** Mr Brendan Gervin and Mrs Alice McAleer	**Registered Manager:** Mrs Noreen Moran, Acting
Person in charge at the time of inspection: Mrs Noreen Moran	**Number of registered places:** 40 Including a maximum of one patient within category NH-LD/LD(E) and two patients within category NH-MP/MP(E). There shall be a maximum of five patients in category NH-DE. The home is also approved to provide care on a day basis for one person.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years LD – learning disability LD(E) – learning disability – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 34
Brief description of the accommodation/how the service operates: This is a registered nursing home which provides nursing care for up to 40 patients. Patients' bedrooms are located over two floors in the home and patients have access to communal lounges and dining rooms.	

2.0 Inspection summary

An unannounced inspection took place on 27 September 2022, from 10.30am to 2.30pm. This was completed by a pharmacist inspector.

The inspection 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.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines.

The outcome of this inspection concluded that improvement in one area of the management of medicines was necessary. This area for improvement regarding the medicine refrigerator is detailed in the quality improvement plan.

Whilst an area for improvement was identified, it was concluded that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed.

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. Staff and patients views were also obtained.

4.0 What people told us about the service

The inspector met with nursing staff and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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.

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?

The last care inspection was undertaken on 28 July 2022 by a care inspector; no areas for improvement were identified.

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.

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 were written and updated to state 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.

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 for two patients 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. One administration record was not always completed. This was highlighted to the manager for close monitoring.

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 out of 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?

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.

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. 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.

Daily temperature records for the medicine refrigerator were reviewed. The maximum and minimum temperatures were outside of the recommended range on multiple occasions over the past two months. No action had been taken. This was highlighted to the manager for urgent action. An area for improvement was identified.

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 close monitoring. The records were filed once completed.

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 medicine administration on a regular basis within the home. A range of audits were carried out. Staff were reminded of the importance of recording the date of opening on all medicines so that they can be easily audited.

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 a patient who had a recent hospital stay and was discharged to this home. A hospital discharge letter had been received and a copy had been forwarded to the patient's GP. 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.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. A small number of minor discrepancies were highlighted to the manager for ongoing close monitoring and review.

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.

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 sessions with staff and at annual appraisal.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement was identified where action is required to ensure compliance with the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The area for improvement and details of the Quality Improvement Plan were discussed with Mrs Noreen Moran, Manager and Mrs Joan McGuckin, Registered Nurse, 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 Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that the medicine refrigerator temperature is maintained within the required range of 2-8^{o}C. Ref: 5.2.2
	Response by registered person detailing the actions taken: The fridge has been replaced. Arrangements for monitoring and reporting any deviations from the range have been reveiwed and shared with staff delegated to complete this task. Oversight arrangements in place to drive and ensure imrpovement.

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