The Regulation and Quality Improvement Authority

Inspection Report

30 June 2022

Drombane

Type of Service: Nursing Home
Address: 39 Glen Road, Blackskull, Dromore, BT25 1JX
Tel no: 028 4062 6064

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: Mrs Elizabeth Kathleen Mary Lisk **Responsible Individual:** Mrs Elizabeth Kathleen Mary Lisk	**Registered Manager:** Mrs Daizy Samuel **Date registered:** 9 January 2015
Person in charge at the time of inspection: Mrs Daizy Samuel	**Number of registered places:** 20 Category NH-MP for one identified patient only.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. MP – Mental disorder excluding learning disability or dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 19
Brief description of the accommodation/how the service operates: Drombane is a registered nursing home which provides nursing care for up to 20 persons. Patient bedrooms are located over two floors. Patients have access to communal lounges, a dining room and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 30 June 2022, from 9.45am to 12.35pm. 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.

Following discussion with the aligned care inspector, it was agreed that the five areas for improvement identified at the last care inspection would be followed up at the next care inspection.

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 and patients were administered their medicines as prescribed. One area for improvement was identified relating to the labelling of insulin pen devices.

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 medicines management.

RQIA would like to thank the manager and 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 the manager and one nurse. 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, one questionnaire was returned. The respondent indicated that they were very satisfied with all aspects of care and that the service was well led.

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 8 June 2021		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 41 **Stated:** First time	The registered person shall ensure that the staffing arrangements in the home are sufficient in meeting patients' needs over the 24 hour period. The duty rota must include first and surnames of all staff and the designation in which they work.	**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 41 **Stated:** First time	The registered person shall ensure that the duty rota includes the first name and surname of all staff members and includes the designation in which they work at all times.	**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 3 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that patients' care plans are updated to reflect visiting professionals' recommendations to changes in care. Any changes to nutritional status should also be communicated with the kitchen staff.	**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 4 **Ref:** Standard 4 Criteria (9) **Stated:** First time	The registered person shall ensure that repositioning charts in the home are completed in full and signed by both staff members who conducted 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.**	**Carried forward to the next inspection**
Area for improvement 5 **Ref:** Standard 11 **Stated:** First time	The registered person shall ensure that the provision of activities in the home is reviewed to make sure that meaningful activities are provided to patients on a regular and consistent approach. **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.**	**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 medical 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.

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 nurses 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 nurses 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 the management of distressed reactions was reviewed for two patients. Directions for use were clearly recorded on the personal medication records; care plans directing the use of these medicines were in place. The nurses knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain.

The management of pain was discussed. The 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. A speech and language assessment report and care plan were in place. Records of prescribing and administration were maintained. However, the recommended consistency level was not always recorded on the personal medication records. This was discussed with the manager and nurse and an assurance was given that the omissions would be rectified without delay.

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 too high or too low.

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 medicines 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.

The medicines storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was 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.

The audits completed at the inspection indicated that the medicines were being administered as prescribed.

Several audits that were attempted on insulin were inconclusive due to the non-recording of the dates of opening of the insulin pen devices. Also, two insulin pen devices were not labelled with the patients' names. This is necessary to provide a clear audit trail and facilitate disposal at expiry. The management of insulin pen devices needs to be reviewed to ensure that they are always labelled with the patient's name and the date of opening. An area for improvement was identified

A sample of the medicines administration records was reviewed. The records were found to have been completed in a satisfactory manner.

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. Records were maintained to the required standard.

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

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 relevant healthcare professionals. 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.

The manager and nurse were familiar with the type of incidents that should be reported.

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 they 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 Quality Improvement Plan/Areas for Improvement

One new area for improvement has been 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	6*

* The total number of areas for improvement includes five which are carried forward for review at the next inspection.

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Daizy Samuel, 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 Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 8 July 2021	The registered person shall ensure that the staffing arrangements in the home are sufficient in meeting patients' needs over the 24 hour period. The duty rota must include first and surnames of all staff and the designation in which they work. **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.** Ref: 5.1
Area for improvement 2 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 8 July 2021	The registered person shall ensure that the duty rota includes the first name and surname of all staff members and includes the designation in which they work at all times. **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.** Ref: 5.1
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 8 July 2021	The registered person shall ensure that patients' care plans are updated to reflect visiting professionals' recommendations to changes in care. Any changes to nutritional status should also be communicated with the kitchen staff. **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.** Ref: 5.1

Area for improvement 4 **Ref:** Standard 4 Criteria (9) **Stated:** First time **To be completed by:** 8 July 2021	The registered person shall ensure that repositioning charts in the home are completed in full and signed by both staff members who conducted 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. Ref: 5.1
Area for improvement 5 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 8 July 2021	The registered person shall ensure that the provision of activities in the home is reviewed to make sure that meaningful activities are provided to patients on a regular and consistent approach.
	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. Ref: 5.1
Area for improvement 6 **Ref**: Standard 28 **Stated:** First time **To be completed by:** With immediate effect (30 June 2022)	The registered person shall ensure that the management of insulin pen devices is reviewed to ensure they are always labelled with the patient's name and the date of opening. Ref: 5.2.3
	Response by registered person detailing the actions taken: This was sorted immediately. All Nurses have been informed that in future when patient comes from community with insulin pens, they must be labelled with name and date of opening.

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

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