Inspection Report

10 July 2024

Croagh Patrick Care Home

Type of service: Nursing Home
Address: Miller Hill, 235 Millisle Road, Donaghadee, BT21 0LN
Telephone number: 028 9188 8383

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: Beaumont Care Homes Limited **Responsible Individual:** Mrs Ruth Burrows	**Registered Manager:** Ms Karen Blair **Date registered:** 22 September 2023
Person in charge at the time of inspection: Ms Karen Blair	**Number of registered places:** 67
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 TI – terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 58
Brief description of the accommodation/how the service operates: Croagh Patrick Care Home is a nursing home registered to provide nursing care for up to 67 patients. Patients' bedrooms, communal lounges and dining rooms are located over both floors of the home. Patients have access to a large garden with patios and seating areas.	

2.0 Inspection summary

An unannounced inspection took place on 10 July 2024, from 10.10am to 3.20pm. This was completed by two pharmacist inspectors. This inspection focused on medicines management within the home and also assessed progress with the area for improvements identified at the last medicine management inspection. 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 areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines. Medicine records 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.

The outcome of this inspection concluded that the areas for improvement identified at the last medicines management inspection had been addressed. No new areas for improvement were 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 regarding 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 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. Discussions took place 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 inspectors met nursing staff, the clinical lead nurse, the deputy manager and the manager. 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.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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?

Areas for improvement from the last care inspection on 20 and 21 July 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that records for the administration of thickening agents are accurately maintained and include the recommended consistency level.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met. See section 5.2.1.	
Area for Improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that the temperature of the medicine refrigerators is accurately monitored and recorded each day.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met. See section 5.2.2.	
Area for Improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that hand-written medication administration records are clearly maintained and include the month and year.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met. See section 5.2.3.	

Area for Improvement 4 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time	The registered person shall ensure that the staff appraisal planner is completed and that all staff receive a recorded annual appraisal within a reasonable timeframe. **Action required to ensure compliance with this regulation 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:** Regulation 19 (1) (b) **Stated:** First time	The registered person shall ensure that records are securely stored at all times. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 18 **Stated:** First time	The registered person shall review and revise the management of distressed reactions to ensure that: • the reason for and outcome of administration is recorded • regular use is referred to the prescriber for review. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met. See section 5.2.1.	**Met**
Area for Improvement 2 **Ref:** Standard 28 **Stated:** First time	The registered person shall implement a robust audit system which covers all aspects of the management of medicines. Any shortfalls identified should be detailed in an action plan and addressed. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met. See section 5.2.3.	**Met**

Area for improvement 3 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure that supplemental records and daily records are accurately and contemporaneously maintained for all areas of care including, where necessary, bowel movements and total daily fluid intake.	**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 4.9 **Stated:** First time	The registered person shall ensure that relevant care plans include details of actions to take in the event of variances to the planned care or in patients' usual presentation regarding bowel habits and fluid intake. Care records should demonstrate registered nurses oversight of all aspects of patients' daily care and, where necessary, actions taken as a result of variances.	**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 5 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that the mealtime is a positive, well organised and enjoyable experience for all patients in the home.	**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.	

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 mostly 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. One discrepancy was highlighted to nurses for immediate action.

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.

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. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place for the majority of patients prescribed these medicines. One patient required a care plan and this was highlighted to nurses for immediate action. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome of each administration.

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 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.

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

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 outside of the recommended range. Nurses were reminded that in use insulin pen devices must be individually labelled and the date of opening recorded to facilitate audit and disposal at expiry.

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.

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. Medicine refrigerators and controlled drugs cabinets 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.

A sample of the medicines administration records was reviewed. The records reviewed were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for audit/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 should be recorded in the controlled drug record book. Records were mostly well maintained, two missing entries were highlighted to nurses and the manager for ongoing close monitoring. These medicines had been administered and reconciled appropriately.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Written consent and care plans were in place when this practice occurred.

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.

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 or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. 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 medicines were being administered as prescribed.

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.

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

	Regulations	Standards
Total number of Areas for Improvement	2*	3*

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

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

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** 30 November 2023	The registered person shall ensure that the staff appraisal planner is completed and that all staff receive a recorded annual appraisal within a reasonable timeframe.
	Action required to ensure compliance with this regulation 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:** Regulation 19 (1) (b) **Stated:** First time **To be completed by:** With immediate effect (21 July 2023)	The registered person shall ensure that records are securely stored at all times.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Action required to ensure compliance with the Care Standards for Nursing Homes (2022)	
Area for improvement 1 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect (21 July 2023)	The registered person shall ensure that supplemental records and daily records are accurately and contemporaneously maintained for all areas of care including, where necessary, bowel movements and total daily fluid intake.
	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 4.9 **Stated:** First time **To be completed by:** With immediate effect (21 July 2023)	The registered person shall ensure that relevant care plans include details of actions to take in the event of variances to the planned care or in patients' usual presentation regarding bowel habits and fluid intake. Care records should demonstrate registered nurses oversight of all aspects of patients' daily care and, where necessary, actions taken as a result of variances.
	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 12 **Stated:** First time **To be completed by:** With immediate effect (21 July 2023)	The registered person shall ensure that the mealtime is a positive, well organised and enjoyable experience for all patients in the home.
	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

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