

# Inspection Report

**Name of Service:** Kingsland Care Centre

**Provider:** Ann's Care Homes

**Date of Inspection:** 17 December 2024

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

## 1.0 Service information

<b>Organisation:</b>	Ann's Care Homes
<b>Responsible Individual</b>	Mrs Charmaine Hamilton
<b>Registered Manager:</b>	Mrs Sandra Willis
<b>Service Profile:</b> Kingsland Care Centre is a nursing home registered to provide nursing care for up to 43 patients. Patients' bedrooms are located over two floors. Patients have access to communal lounges and dining rooms and a patio area.	

## 2.0 Inspection summary

An unannounced inspection took place on 17 December 2024, from 10.15am to 2.15pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The inspection also reviewed the areas for improvement identified at the last medicines management inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. 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. However, one area for improvement in relation to cold storage of medicines, was stated for a second time.

Whilst an area for improvement was restated, there was evidence that patients were being administered their medicines as prescribed.

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

The areas for improvement in relation to medicine audits and pain care plans, identified at the last medicines management inspection, were assessed as met. One area for improvement was stated for a second time, in relation to the cold storage of medicines. Details can be found in the quality improvement plan (QIP) (Section 4.0).

RQIA would like to thank the staff for their assistance throughout the inspection.

### **3.0 The inspection**

#### **3.1 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 against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

#### **3.2 What people told us about the service and their quality of life**

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. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each patient liked to take their medicines and medicines were administered in accordance with individual patient preference. Staff also said that they prioritised patients who required pain relief and time-critical medicines during each medicine round.

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

### 3.3 Inspection findings

#### 3.3.1 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. 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 confirm that they were accurate. A small number of minor discrepancies were highlighted to nurses for immediate corrective action and on-going vigilance.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

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.

The management of distressed reactions, pain, thickening agents and insulin was reviewed. Most care plans contained sufficient detail to direct the required care. One care plan for the management of insulin required an update to reflect the most recent prescription. This was highlighted to the manager for immediate action. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

#### 3.3.2 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.

Records reviewed 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 medicine storage areas were observed to be securely locked to prevent any unauthorised access. They were 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.

Medicines which require cold storage must be stored between 2°C and 8°C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The maximum temperature of one medicine refrigerator had exceeded the recommended range on numerous days and appropriate action had not been taken. An area for improvement was stated for the second time.

The manager was reminded that medicines awaiting collection for disposal should be stored securely to prevent unauthorised access and collected in a timely manner.

### **3.3.3 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 medicine administration records was reviewed. Records were found to have been accurately completed. 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. 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. There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

### **3.3.4 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 at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

### **3.3.5 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.

### **3.3.6 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.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

## **4.0 Quality Improvement Plan/Areas for Improvement**

An area for improvement has been restated where action is required to ensure compliance with Regulations.

	<b>Regulations</b>	<b>Standards</b>
<b>Total number of Areas for Improvement</b>	1	0

The area for improvement that has been restated and details of the Quality Improvement Plan were discussed with Mrs Sandra Willis, Registered Manager, and the 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	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 13(4)  <b>Stated:</b> Second time  <b>To be completed by:</b> 17 December 2024	The registered person shall ensure a robust daily monitoring system for the cold storage of medicines is maintained to ensure that the minimum and maximum medicine refrigerator temperatures are recorded, the thermometer is reset every day and medicines are stored in accordance with the manufacturers' instructions.  Ref: 3.3.2
	<b>Response by registered person detailing the actions taken:</b> A new medical fridge has been purchased for downstairs treatment room. A new temperature recording sheet has been implemented to support more effective monitoring. A list of common medications that require re Fridgeration is displayed on the medical fridge door on both floors. A supervision session has been held with all nurses advising of actions to take if fridge tempaeratures are outside the acceptable range.The Home Manager will monitor compliance via spot checks and a monthly medication audit.

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The Regulation and  
Quality Improvement  
Authority

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