The Regulation and Quality Improvement Authority

Inspection Report

28 September 2021

Kingsland Care Centre

Type of Service: Nursing Home
Address: 252 Seacliff Road, Bangor, BT20 5HT
Tel no: 028 9127 3867

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: Larchwood Care Homes (NI) Limited **Responsible Individual:** Mr Christopher Walsh	**Registered Manager:** Ms Ruth McKeown **Date registered:** 12 February 2019
Person in charge at the time of inspection: Ms Ruth McKeown	**Number of registered places:** 43
Categories of care: Nursing Home (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:** 38
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 43 patients. Patients' bedrooms are located over two floors.	

2.0 Inspection summary

An unannounced inspection took place on 28 September 2021 from 10.15am to 3.30pm. The inspection was conducted by a pharmacist inspector and focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care and medicines management inspections.

Review of medicines management identified there were arrangements in place to ensure that staff were trained and competent in medicines management. Medicine records were well maintained and readily available for inspection. Three areas for improvement in relation to the cold storage of medicines, care plans for the management of pain and medicines audit were identified.

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. To complete the inspection 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 were reviewed.

4.0 What people told us about the service

We met with two nursing staff, the manager and the registered person. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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

Staff expressed satisfaction with how the home was managed. They 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 registered 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 last inspection?

No areas for improvement were identified at the last medicines management inspection on 14 May 2018.

Areas for improvement from the last inspection on 18 May 2021		
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) (c) **Stated:** Second time	The registered person shall ensure that all chemicals are securely stored to comply with Control of Substances Hazardous to Health (COSHH) in order to ensure that patients are protected from hazards to their health.	**Met**
	Action taken as confirmed during the inspection: Chemicals were observed to be stored safely and securely in the home to comply with COSHH. Key code locks had been installed on sluice room doors preventing unauthorised access.	
Area for improvement 2 **Ref:** Regulation 14 (2) (c) **Stated:** First time	The registered person shall ensure that all patients have access to the nurse call system; this relates to the provision of nurse call leads within patient bedrooms, as appropriate.	**Met**
	Action taken as confirmed during the inspection: Review of patient bedrooms evidenced patients had access to the nurse call system. Nurse call leads were observed to be easily accessible for patients. This was routinely monitored by management in the home.	

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 will 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 nurse had verified and signed the personal medication records when they were written and updated to provide a check 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.

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, self-administration 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 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 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 the management of distressed reactions was reviewed. Staff 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. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. Records of administration were clearly recorded. The reason for and outcome of administration were recorded in supplementary "when required" medicine administration records.

The management of pain was reviewed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required.

However, care plans in relation to pain were not in place to direct staff. There was no evidence of regular patient pain assessments. An area for improvement was identified.

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 three patients was reviewed. A speech and language assessment report and nutritional care plan were in place for each patient. 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. In-use insulin pens were individually labelled and the date of opening was recorded in order 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?

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 securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. In relation to the cold storage of medicines, the minimum and maximum medicine refrigerator temperatures of the downstairs refrigerator had not been monitored and recorded appropriately for three weeks in September 2021. To ensure that medicines are stored in accordance with the manufacturers' instructions, staff must ensure that refrigerators are maintained between 2°C and 8°C. An area for improvement was identified.

Satisfactory arrangements for the disposal of medicines were in place and records were maintained.

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 medicine administration records (MARs).

A sample of these 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 and were readily available 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 are recorded in a controlled drug record book. On one occasion when subcutaneous morphine had been administered to a patient nursing staff had recorded the amount administered from the ampoule but did not document the quantity discarded. This was an isolated incident and nursing staff were reminded to consistently document the amount of controlled drug discarded.

The audits completed during the inspection showed that the majority of medicines had been administered as prescribed. However, one patient had a missed dose of an analgesic pain patch which is prescribed to be changed once per week. Discrepancies were also noted in four other medicines indicating they had not been administered as prescribed. This was discussed with the manager on the day of inspection for investigation and review. An incident report detailing the outcome of the investigation and action taken to prevent a recurrence was submitted to RQIA on 28th September 2021.

Although management and staff audited medicine administration on a regular basis within the home, the audits had not been effective in identifying the discrepancies noted during this inspection indicating that the auditing system is not robust. An area for improvement was identified.

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.

The management of medicines for one patient recently admitted to the home from hospital was reviewed. A hospital discharge letter had been received and a copy had been forwarded to the patient's GP. The patient's personal medication record had been written accurately. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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.

As detailed in Section 5.2.3, the findings of this inspection indicated the auditing system is not robust and therefore incidents were not identified. The need for a robust auditing system which covers all aspects of medicines management is necessary to ensure safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.

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

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.

Records of staff training in relation to medicines management were available for inspection. The manager provided evidence that further external training in medicines management was currently being arranged.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include the cold storage of medicines, care plans for the management of pain and medicines audit.

Although areas for improvement were identified, we can conclude that overall, with the exception of a small number of medicines, the patients were administered their medicines as prescribed by their GP.

We would like to thank the patients and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	2	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Christopher Walsh, Registered Person and Ms Ruth McKeown, 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 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	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: 5.2.2
	Response by registered person detailing the actions taken: A new thermometer has been put insitu, Staff are recording daily temperatures, indicating minimum and maximum readings. Staff are aware to report any issues to the home manager. Spot checks are carried out by the Home Manager to ensure these are completed.
Area for improvement 2 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** From the date of inspection	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. Ref: 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: The Home Manager is conducting monthly audits- with action plans/timescales where necessary. External pharmacy audit was completed 5/10/21. Staff nurses are conducting one audit per shift specifically looking at one individual resident to ensure all information is up to date, with any areas of concern then being highlighted to the manager for action.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that care plans for the management of pain are in place and are regularly reviewed for patients who are prescribed medications for the management of pain. Ref: 5.2.1

To be completed by: From the date of inspection	
	Response by registered person detailing the actions taken: Staff nurses where informed at staff meeting held 6/10/21 that pain management care plans where to be updated. These have now all been updated and individualised for each resident.

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

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