The Regulation and Quality Improvement Authority

Inspection Report

15 April 2021

Nazareth House Care Village

Type of Service: Residential Care Home
Address: 516 Ravenhill Road, Belfast, BT6 0BW
Tel No: 028 9069 0600

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Poor Sisters of Nazareth **Responsible Individual:** Mr John O'Mahoney	**Registered Manager:** Mrs Carmel Blaney **Date registered:** 12 June 2020
Person in charge at the time of inspection: Mrs Carmel Blaney	**Number of registered places:** 28
Categories of care: Residential Care (RC): I – Old age not falling within any other category. DE – Dementia.	**Number of residents accommodated in the residential care home on the day of this inspection:** 27
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 28 residents.	

2.0 Inspection summary

An unannounced inspection took place on 15 April 2021, from 09.45 am to 12.40 pm by a pharmacist inspector.

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to the management of medicines.

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

Based on the inspection findings and discussions held we 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 manager in relation to the management of medicines.

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 the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to a resident
- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication
- medicine administration
- medicine receipt and disposal
- controlled drug
- care plans related to medicines management
- governance and audit
- staff training and competency
- medicine storage temperatures
- RQIA registration certificate

4.0 What people told us about the service

Staff were warm and friendly and it was evident from their interactions that they knew the residents well. They were wearing face masks and other personal protective equipment (PPE) as needed.

Staff spoken to expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after residents and meet their needs.

Residents were relaxing in either their own rooms or in the lounge. One resident said that they were more than happy with the care they received and that the staff and manager were excellent.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. Four questionnaires were returned within the allocated time. The respondents indicated that they were very satisfied/satisfied with all aspects of care. One respondent stated that the level of care was excellent and was to be praised. Another respondent stated that management is excellent.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection and last medicines management inspection?

The last inspection to this residential care home was undertaken on 9 February 2021 by a care inspector; no areas for improvement were identified.

Areas for improvement from the last medicines management inspection on 15 March 2018		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 32 **Stated:** First time	The registered person shall ensure that the management of the temperature in the medicines storage area is reviewed to ensure that it does not exceed 25°C.	**Met**
	Action taken as confirmed during the inspection: The temperature of the medicines storage area was monitored and recorded each day. Since 1 March 2021, the temperature had been maintained within the range 23°C to 25°C. The temperature during the inspection was 24°C.	
Area for Improvement 2 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that written policies and procedures are revised to reflect that residential care is provided and that the disposal of medicines is appropriate for a residential care home.	**Met**
	Action taken as confirmed during the inspection: The written medicines management policies and procedures had been revised to reflect that residential care was provided and that the disposal of medicines was appropriate for a residential care home. .	

5.2 Inspection outcome

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' 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.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. 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 e.g. medication reviews, 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 provide a double check that they were accurate.

Copies of residents' 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 residents 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.

Residents 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 resident's distress and if the prescribed medicine is effective for the resident. 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 resident'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. These medicines were infrequently used.

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

Some residents 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 resident 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 resident. 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.

Care plans were in place when residents self-administer medicines.

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 resident'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 residents 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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Discontinued medicines were returned to the community pharmacy for disposal and records 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 residents to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs, when medicines are administered to a resident. A sample of these records was reviewed. The records were found to have been fully and accurately completed. The completed 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 were recorded in a controlled drug record book. Stock balance checks were performed on controlled drugs at each staff handover.

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.

The audits completed during this inspection showed that medicines had been given as prescribed.

The medicine cups used to facilitate the administration of medicines to residents were labelled as single use. However, the manager and staff advised that the cups were washed after use and then reused. This matter was discussed with the manager who gave an assurance that the necessary arrangements would be made to ensure that this practice is stopped and the medicine cups are used in the manner intended.

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 recently admitted resident and also for one resident who had been readmitted to the home from hospital were reviewed. A hospital discharge letter had been received or the medication prescribed had been confirmed with the GP practice as an integral part of the admission and readmission process. The residents' personal medication records and MARs had been accurately maintained. Medicines had been 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.

The audit system in place helps staff to identify medicine related incidents. Management and staff 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 residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff 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.

Records of staff training in relation to medicines management were available for inspection. A written record was completed for induction and competency assessments.

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 in relation to the management of medicines.

The outcome of this inspection concluded that all 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 we 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. We can conclude that overall the residents were being administered their medicines as prescribed by their GP.

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

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified.

Findings of the inspection were discussed with Mrs Carmel Blaney, Manager, as part of the inspection process and can be found in the main body of the report.

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