The Regulation and Quality Improvement Authority

# Inspection Report

## 11 May 2021

# Lisburn Intermediate Care Centre

Type of Service: Nursing Home
Address: 119b Hillsborough Road, Lisburn, BT28 1JX
Tel No: 028 9266 9523

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

## 1.0 Service information

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| **Organisation/Registered Provider:**<br>Four Seasons Healthcare<br><br>**Responsible Individual:**<br>Mrs Natasha Southall | **Registered Manager:**<br>Mrs Alfie Corvera<br><br>**Date registered:**<br>19 March 2020 |
| **Person in charge at the time of inspection:**<br>Mrs Alfie Corvera | **Number of registered places:**<br>63<br><br>There shall be a maximum of 12 patients accommodated within category of care NH-DE and located within the designated dementia unit (lower ground floor). |
| **Categories of care:**<br>Nursing (NH):<br>I – Old age not falling within any other category.<br>DE – Dementia.<br>PH – Physical disability other than sensory impairment.<br>PH(E) - Physical disability other than sensory impairment – over 65 years.<br>TI – Terminally ill. | **Number of patients accommodated in the nursing home on the day of this inspection:**<br>52 |
| **Brief description of the accommodation/how the service operates:**<br><br>This is a nursing home which is registered to provide care for up to 63 patients. | |

## 2.0 Inspection summary

An announced inspection took place on 13 May 2021, from 9.45 am to 3.00 pm. The inspection was completed by two pharmacist inspectors.

Short notice of the inspection was provided to the manager in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

This inspection focused on medicines management within the home. Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last inspection would be followed up at the next care inspection.

We can conclude that the patients were being administered their medicines as prescribed. 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 with respect 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 we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- 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 records
- medicine administration
- medicine receipt and disposal
- controlled drugs
- 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

The inspectors met with the manager and four registered nurses. 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 also said that they had the appropriate training to look after patients and meet their needs. They spoke highly of the support given by management and the communication within the home.

In order to reduce the footfall throughout the home, the inspectors did not meet with any patients during the inspection.

However, feedback methods included a staff poster and paper questionnaires which were provided for any patient or their representative to complete and return using pre-paid, self-addressed envelopes.

Five questionnaires were returned from relatives within the allocated timeframe. The respondents indicated that they were very satisfied with all aspects of care.

## 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 March 2021** | | |
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| **Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005** | | **Validation of compliance** |
| **Area for Improvement 1**<br><br>**Ref:** Regulation 13 (7)<br><br>**Stated:** First time | The registered person shall ensure that the nurse in charge of the home, in the absence of the manager, has access to additional supplies of PPE. | **Carried forward to the next inspection** |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** | |
| **Action required to ensure compliance with Care Standards for Nursing Homes, April 2015** | | **Validation of compliance summary** |
| **Area for Improvement 1**<br><br>**Ref:** Standard 4<br><br>**Stated:** First time | The registered person shall ensure that care plans are updated to accurately reflect any changes to wounds and the associated dressing regime. | **Carried forward to the next inspection** |
| | **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** | |

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| **Area for Improvement 2**<br><br>**Ref:** Standard 4.9<br><br>**Stated:** First time | The registered person shall ensure that the dual system of recording daily fluids is reviewed to ensure that daily fluid intakes are consistently and accurately recorded. | **Carried forward to the next inspection** |
| | **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** | |

## 5.2 Inspection outcome

### 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 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 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. Whenever a patient had more than one personal medication record in current use, this was not recorded on each sheet; this matter was drawn to the manager's attention to address.

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. However, for one patient, the reason for and outcome of administration were not always recorded; this matter was drawn to the manager's attention to address.

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.

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 three patients. A speech and language assessment report and care plan was in place. Records of prescribing and administration, which included the recommended consistency level, were generally maintained. However, for one patient the consistency level was not recorded on their personal medication record; this matter was drawn to the manager's attention to address.

### 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 staff at the community and hospital pharmacies 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. Medicine refrigerators and controlled drugs cabinets were available for use as needed.

The dates of opening had not been recorded on two insulin pens; this matter was drawn to the manager's attention to address.

We reviewed the disposal arrangements for medicines. 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 patients 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 patient. A sample of these records was reviewed and was found to have been completed to a high standard. The 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 controlled drug record books, which had been completed in a satisfactory manner. Stock checks of controlled drugs were performed at each staff shift 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 most medicines so that they could be easily audited; this is good practice.

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

### 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.

We reviewed the management of medicines for three patients who had either been admitted or had a hospital stay and were discharged back to this home. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. The patients' personal medication records and MARs had been accurately written. 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.

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.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

### 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.

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.

## 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.

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 the patients were being administered their medicines as prescribed.

No new areas for improvement were identified.

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

## 7.0 Quality Improvement Plan/Areas for Improvement

| | Regulations | Standards |
|---|---|---|
| **Total number of Areas for Improvement** | 1* | 2* |

* the total number of areas for improvement includes three that are carried forward for review at the next inspection.

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

## Quality Improvement Plan

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| **Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005** | |
| **Area for improvement 1**<br><br>**Ref:** Regulation 13 (7)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Ongoing from the day of the inspection | The registered person shall ensure that the nurse in charge of the home, in the absence of the manager, has access to additional supplies of PPE. |
| | **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.**<br><br>Ref: 5.1 |
| **Action required to ensure compliance with Care Standards for Nursing Homes, April 2015** | |
| **Area for improvement 1**<br><br>**Ref:** Standard 4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>5 April 2021 | The registered person shall ensure that care plans are updated to accurately reflect any changes to wounds and the associated dressing regime. |
| | **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.**<br><br>Ref: 5.1 |
| **Area for improvement 2**<br><br>**Ref:** Standard 4.9<br><br>**Stated:** First time<br><br>**To be completed by:**<br>5 April 2021 | The registered person shall ensure that the dual system of recording daily fluids is reviewed to ensure that daily fluid intakes are consistently and accurately recorded. |
| | **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.**<br><br>Ref: 5.1 |

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