

# Inspection Report

**Name of Service:** Culmore Manor Care Centre

**Provider:** Ann's Care Homes

**Date of Inspection:** 11 September 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/Registered Provider:</b>	Ann's Care Homes
<b>Responsible Individual:</b>	Mrs Charmaine Hamilton
<b>Registered Manager:</b>	Mrs Kelly McCready
<b>Service Profile</b> Culmore Manor Care Centre is a registered nursing home which provides nursing care for up to 56 patients.	

## 2.0 Inspection summary

An unannounced medicines management inspection took place on 11 September 2024, from 10.00am to 2.30pm. This was completed by a pharmacist inspector and focused on medicines management within the home. 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 outcome of this inspection concluded that robust arrangements were not in place for some aspects of medicines management. Four new areas for improvement were identified in relation to the management of insulin, governance and audit, record keeping and repairs to the treatment room. Details of the areas for improvement can be found in the quality improvement plan.

Following the inspection, the findings were discussed with the Senior Pharmacist Inspector in RQIA and with Mrs Charmaine Hamilton, Responsible Individual. RQIA requested that an action plan to address the deficits identified during the inspection be submitted. It was decided that a period of time would be given to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

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.

The inspection was completed by reviewing 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, to evidence how the home is performing in relation to the regulations and standards. Discussions were held with staff and management about how they plan, deliver and monitor the management of medicines.

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

Throughout the inspection the RQIA inspector will seek to speak with patients, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home.

The inspector spoke with nursing staff and the manager to seek their views of working in the home.

Staff expressed satisfaction with how the home was managed. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

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.

### 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 personal medication records reviewed were largely 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.

All patients should have care records 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.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care records 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 and care records directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. The reason and outcome of each administration was recorded in some but not all instances when these medicines were administered. This was highlighted to the manager for ongoing monitoring and inclusion in the home's internal audit process.

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 records 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 records 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 were reviewed. Speech and language assessment reports and care records were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Review of the management of insulin, a high risk medicine, identified safe systems were not in place. Obsolete insulin related records had not been removed from the medicine file and suitably archived. This is necessary to ensure that nurses do not refer to these records in error which could lead to an incorrect insulin dose being administered. Some of the in-use insulin pens were not individually labelled to denote ownership. In addition, the date of opening had not been recorded accurately on one in-use insulin pen. This is necessary to facilitate audit and disposal at expiry. Safe systems must be in place to ensure patients are administered the correct insulin dose i.e. clear records of prescribing, administration, disposal at expiry and audit. An area for improvement was identified.

### **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 the large majority of medicines were available for administration when patients required them. Two medicines which had been out of stock for a period of one and two days respectively were highlighted to the manager for review and investigation.

The medicine storage areas were observed to be securely locked to prevent any unauthorised access. However, the downstairs treatment room floor was in a state of disrepair and the room was heavily cluttered and untidy. This meant the room could not be effectively cleaned and did not conform to infection prevention and control measures. An area for improvement was identified.

Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

Satisfactory arrangements were in place for the safe disposal of medicines.

### **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 medicines administration records was reviewed. Unexplained gaps were observed in the administration records, including the administration of one antibiotic medicine. There was evidence that medicines had been omitted but signed as administered by nursing staff. Complete and accurate records of the administration of medicines is necessary to provide evidence that patients are administered their medicines as prescribed. An area for improvement was identified.

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. However, the audits completed by the inspector identified a significant number of discrepancies including the administration of medicines prescribed for the management of Parkinson's disease and diabetes, antibiotic medicines, and one anticoagulant medicine.

The date of opening was not consistently recorded on all medicines in order to facilitate audit and corrective action had not been taken when discrepancies were noted.

A robust audit system encompassing all aspects of medicines management is necessary to ensure safe systems are in place and that patients are administered their medicines as prescribed. Any deficits identified through the home's audit process should be detailed in an action plan and steps taken to prevent a recurrence. Statutory notifications submitted to RQIA must contain sufficient detail to provide assurance that they have been robustly managed in keeping with best practice. An area for improvement was identified.

### **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.

Review of medicines for a patient recently admitted from hospital showed that a hospital discharge letter had been received and a copy had been forwarded to the patient's GP. However, discrepancies in the administration of medicines since admission were identified. These were highlighted to the manager for immediate review and investigation. An incident report detailing the actions taken to prevent a recurrence was submitted to RQIA on 13 September 2024.

### 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.

Although auditing systems were in place, the findings of this inspection indicate they were not effective. Nurses had not escalated errors to the manager and corrective action had not been taken to prevent incidents recurring. As stated in Section 3.3.3, the issues raised at this inspection were not being identified and the audit system should be reviewed and improved.

### 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.

The findings of this inspection indicate that medicines management training had not been effective in improving practice. The action plan submitted by the home following the inspection indicated all nursing staff would undergo further medicines management training and competency assessment to ensure improvements are implemented and sustained.

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

## 4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	3*	8*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Kelly McCreedy, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005</b>	
<p><b>Area for improvement 1</b></p> <p><b>Ref:</b> Regulation 13 (4)</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> From the date of inspection (11 September 2024)</p>	<p>The registered person shall ensure safe systems are in place for the management and administration of insulin.</p> <p>Ref: 3.3.1</p> <p><b>Response by registered person detailing the actions taken:</b> The particular management programme identified during the inspection came under review after the inspection and staff were able to ascertain that the instructions for the management of insulin for the identified patient were accurate, although the recording keeping required improvements. The historical records were archived and clear written instructions for the prescription and administration of insulin was implemented. Other residents on insulin were also assessed and the Home ensured that accurate and clear records were in place</p>
<p><b>Area for improvement 2</b></p> <p><b>Ref:</b> Regulation 13 (4)</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> From the date of inspection (11 September 2024)</p>	<p>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.</p> <p>Ref: 3.3.3 &amp; 3.3.5</p> <p><b>Response by registered person detailing the actions taken:</b> The Home implemented a range of audit programmes in the Home, these included daily audits during the working week of individual patient medicines, boxed audit counts and additionally there was a comprehensive audit in place for the systems of the Home.</p>
<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Regulation 13 (7)</p> <p><b>Stated:</b> Second time</p> <p><b>To be completed by:</b> From the date of inspection (25 October 2023)</p>	<p>The registered person shall ensure that IPC deficits identified during the inspection are addressed.</p> <p><b>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.</b></p>

<b>Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022</b>	
<p><b>Area for improvement 1</b></p> <p><b>Ref:</b> Standard 29</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> From the date of inspection (11 September 2024)</p>	<p>The registered person shall ensure that fully complete and accurate records of the administration of medicines are maintained.</p> <p>Ref: 3.3.3</p> <p><b>Response by registered person detailing the actions taken:</b> The Home's new audit programme helped to identified any issues with the medication systems and new processes were put in place to support the accurate recording of medication management in the Home</p>
<p><b>Area for improvement 2</b></p> <p><b>Ref:</b> Standard 30</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 4 December 2024</p>	<p>The registered person shall ensure the deficits identified in the downstairs treatment room as detailed in the report are suitably addressed.</p> <p>Ref: 3.3.2</p> <p><b>Response by registered person detailing the actions taken:</b> The downstairs treatment room was refurbished to include new cupboards, a new flooring, worksurfaces and sink areas. All new cabinet that require securing can now be locked appropriately</p>
<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Standard 12</p> <p><b>Stated:</b> Second time</p> <p><b>To be completed by:</b> 25 November 2023</p>	<p>The registered person shall ensure the following in relation to dietary/fluid intake supplementary recording charts:</p> <ul style="list-style-type: none"> <li>• records are signed/dated by the person making the entry</li> <li>• the daily volume of fluid is totalled over 24 hours</li> <li>• contains sufficient information regarding the type of food consumed.</li> </ul> <p><b>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.</b></p>
<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Standard 4</p> <p><b>Stated:</b> Second time</p> <p><b>To be completed by:</b> 25 November 2023</p>	<p>The registered person shall ensure the following in relation to care records:</p> <ul style="list-style-type: none"> <li>• entries made within care records are dated; timed; signed and accompanied with the name and designation of the signatory</li> <li>• details within care plans remain relevant</li> <li>• alterations to care records are signed and dated with the original entry able to read</li> <li>• hand writing is legible.</li> </ul>

	<b>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.</b>
<b>Area for improvement 5</b> <b>Ref:</b> Standard 23 <b>Stated:</b> First time  <b>To be completed by:</b> 25 November 2023	The registered person shall ensure that where a patient requires pressure area care, a care plan is in place detailing the recommended frequency of repositioning; and that this is accurately reflected and recorded in the corresponding repositioning chart.
	<b>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.</b>
<b>Area for improvement 6</b> <b>Ref:</b> Standard 12 <b>Stated:</b> First time  <b>To be completed by:</b> 25 November 2023	The registered person shall ensure that where a patient is at risk of dehydration a recommended daily fluid intake target is recorded within the patients care plan and daily fluid intake chart, with the action to take, and at what stage, if the recommended daily fluid target has not been achieved.
	<b>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.</b>
<b>Area for improvement 7</b> <b>Ref:</b> Standard 4  <b>Stated:</b> First time  <b>To be completed by:</b> From the date of inspection (25 October 2023)	The registered person shall ensure that patients care plans and risk assessments are completed within the required time frame following admission to the home.
	<b>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.</b>
<b>Area for improvement 8</b> <b>Ref:</b> Standard 35 <b>Stated:</b> First time  <b>To be completed by:</b> From the date of inspection (25 October 2023)	The registered person shall ensure that quality governance audits are robust at identifying IPC deficits. With specific reference to ensuring that commodes and wheelchairs are appropriately cleaned following use and between patients.
	<b>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.</b>

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





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