The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: The Somme

Provider: Board of Directors

Date of Inspection: 5 August 2025

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:	Board of Directors
Responsible Individual:	Mr Gary Cassells
Registered Manager:	Mrs Ruth Rogers
Service Profile: The Somme is a nursing home registered to provide nursing care for up to 50 patients, including patients with a terminal illness and patients living with a physical disability other than sensory impairment. The home is a single storey building which is divided into four units; Wilson Liddell Unit, Bates Unit, Eakin Unit and Rogers Unit. There is a large communal dining room and a range of lounges, sitting areas and enclosed outside courtyards.	

2.0 Inspection summary

An unannounced inspection took place on 5 August 2025, from 10.40am to 5.10pm. The inspection 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 and one of the areas for improvement identified at the last care inspection. The two remaining areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were mostly well maintained. There were 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 regarding the management of refrigerated medicines, was stated for a second time and four new areas for improvement were identified. These related to the management of refrigerated medicines, the storage of controlled drugs, the management of insulin, handwritten additions to medication administration records and records for the management of distressed reactions.

The areas for improvement in relation to the storage of dietary supplements and oxygen cylinders, identified at the last care inspection, and the systems for ordering medicines, identified at the last medicines management inspection, were assessed as met.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, new areas for improvement identified and the restated area for improvement, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

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.

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

The patient questionnaires returned indicated that they were satisfied with the management of their medicines and the care received.

A healthcare professional visiting the home at the time of this inspection was positive about their experiences visiting the home.

Nurses advised that they were familiar with how each patient liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

Staff said that they had the appropriate training to look after patients and meet their needs. They said that overall, the team communicated in a satisfactory manner and the management team were available to discuss any concerns should they arise.

A staff member commented on the visibility/approachability of management at times. This was discussed with the manager during feedback, who confirmed that this would be considered and addressed, and with the aligned care inspector in RQIA.

No responses to the staff survey were received 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 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 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 that 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 plans 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 on the personal medication record and care plans 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. However, records

of administration did not always include the reason for and outcome of each administration. An area for improvement was identified.

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 plans were in place and reviewed regularly. One care plan needed to be updated with a recently prescribed medicine, it was agreed that this would be addressed following the inspection.

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 and nutritional supplements was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration, which included the recommended consistency level, were maintained.

The management of insulin was reviewed. Care plans were in place and there was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range. One care plan did not reflect the most recently prescribed insulin regime, the manager agreed to address this immediately to ensure that care plans, personal medication records and administration record sheets match the currently prescribed dose. Some of the insulin pen devices in use were not labelled with the patient details or the date of opening. This is necessary to denote ownership, to facilitate audit and to ensure that medicines that have a reduced shelf life once opened, are not administered after expiry. An area for improvement was identified.

The management of warfarin was reviewed. Warfarin is a high-risk medicine, which requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. Appropriate records had been maintained, warfarin had been administered as prescribed and a patient specific care plan was in place.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined.

An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff advised that they had received training and felt confident to manage medicines and nutrition via the enteral route. It was agreed that the care plan would be updated to ensure that the details matched the current feeding regimen and personal medication record.

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, including the area where nutritional supplements and oxygen were stored, 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. Stock levels were appropriate and all medicines were within their expiry date. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

Medicines that require cold storage must be stored between 2ºC and 8ºC 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 current, maximum and minimum temperatures of the medicine refrigerators were monitored and recorded each day. Although temperatures were satisfactory at the time of the inspection, deviations outside of the recommend range had been identified on a number of occasions in recent months and it was unclear if the necessary action had been taken since deviations were recorded on successive days. The need for staff training, written instructions on refrigerators and escalation processes to management were discussed. An area for improvement was stated for a second time.

The storage of controlled drugs was reviewed, all stock balances were correct. However, temazepam, a Schedule 3 controlled drug requiring storage in the controlled drugs cupboard, was not stored appropriately. An area for improvement was identified.

Satisfactory arrangements were in place for the safe disposal of medicines, however, nurses were reminded that two staff should sign each entry in the record of destruction/disposal.

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. Most of the records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review. However, handwritten additions to medication administration records had not always been reviewed and signed by two nurses to verify accuracy. An area for improvement was identified.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong painkillers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory records in place for the management of controlled drugs.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that medicines were being administered as prescribed and that the findings of the audits had been discussed with staff and addressed.

With the exception of insulin, the date of opening was recorded on medicines to facilitate audit and disposal at expiry. However, as not all of the issues identified at this inspection had been identified through the home's audit processes, it was agreed that audit procedures would be reviewed.

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. There was evidence that any discrepancies had been followed up in a timely manner to ensure that the correct medicines were available for administration. 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 that 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.

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 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. Medicines management policies and procedures were in place.

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

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

	Regulations	Standards
Total number of Areas for Improvement	2*	5*

* the total number of areas for improvement includes one that has been stated for a second time and two which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Ruth Rogers, 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:** Second time **To be completed by:** Immediate and ongoing 5 August 2025	The registered person shall ensure that the management of refrigerated medicines is robust as detailed in the report. Ref: 2.0 & 3.3.2
	Response by registered person detailing the actions taken: The fridge temperature was closely monitored following inspection and had variable temperatures recorded . Temperature probe from kitchen was used and fridge remained in correct temperature range indicating fridge was operating correctly and fault was with thermometer . New fridge thermometer was purchased. As previous recordings had been outside of normal range medication from fridge was discarded and replacements obtained. New fridge temperature recording paperwork was put in place which clearly stated acceptable temperature range and staff instructed to reset thermometer daily .
Area for improvement 2 **Ref:** Regulation 13 (4)	The registered person shall ensure that controlled drugs requiring safe storage are stored in the controlled drugs cabinet in accordance with the relevant legislation.

Stated: First time **To be completed by:** Immediate and ongoing 5 August 2025	Ref: 3.3.2
	Response by registered person detailing the actions taken: The medication that had been in the medicine trolley at time of inspection was immediately returned to the secure controlled drug cupboard . Staff reminded of the correct procedures for storage of controlled medication .

Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 8 August 2025	The registered person shall review the management of distressed reactions to ensure that, the reason for and outcome of administering 'when required' medicines, is recorded on every occasion. Ref: 3.3.1
	Response by registered person detailing the actions taken: A record is kept in the medicine kardex to record the administration of medication for the management of distressed reactions . Staff have been instructed to record symptons of the reaction and the effect of the medication administered
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing 5 August 2025	The registered person shall review the management of insulin to ensure that insulin in use is labelled with the patient details and the date of opening, and that records correlate with the most recent prescribed instructions. Ref: 3.3.1
	Response by registered person detailing the actions taken: Staff reminded to ensure date label is in situ on all insulin pens clearly stating the date the pen has been opened . Pen to be checked daily to ensure date of opening has not exceeded 28 days
Area for improvement 3 **Ref:** Standard 29 **Stated:** First time **To be completed by:** Immediate and ongoing 5 August 2025	The registered person shall ensure that handwritten additions to medication administration records are checked and signed by two nurses to verify accuracy. Ref: 3.3.3
	Response by registered person detailing the actions taken: We are in the process of switching over to the pre printed kardexes created by our pharmacy provider all kardexes will be reviewed and signed by two members of the nursing staff

Area for improvement 4 **Ref:** Standard 39 **Stated:** Second time **To be completed by:** 31 October 2024	The registered person shall ensure that the written training and development plan is kept under review and is regularly updated to reflect the training needs of individual staff to ensure that all mandatory training requirements are met. This includes the Mental Health Capacity Act – Deprivation of Liberty Safeguards (DoLS) training.
	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. Ref: 2.0
Area for improvement 5 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 October 2024	The registered person shall ensure that any actions identified at patient, patients' representative and staff meetings are reviewed and addressed appropriately.
	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. Ref: 2.0

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