

Inspection Report

2 May 2024



The Martin Residential Trust

Type of Service: Nursing Home
Address: 48 Ballyclare Road, Glengormley, BT36 5HL
Telephone number: 028 9034 2365

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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: The Martin Residential Trust | Registered Manager: Mr Martin Kelly |
| Registered Person: Mrs Lisa McFarland | Date registered: 23 December 2021 |
| Person in charge at the time of inspection: Mr Martin Kelly | Number of registered places: 19 |
| Categories of care: Nursing Home (NH) LD – Learning disability LD(E) – Learning disability – over 65 years | Number of patients accommodated in the nursing home on the day of this inspection: 18 |
| Brief description of the accommodation/how the service operates: The Martin Residential Trust is a nursing home registered to provide nursing care for up to 19 patients living with a learning disability. Bedrooms are located over one floor. Patients have access to communal lounges, a dining room and a patio garden area at the rear of the home. | |

2.0 Inspection summary

An unannounced inspection took place on 2 May 2024, from 10.05am to 1.35pm. 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 areas for improvement identified and carried forward at the last inspection were also reviewed.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. The outcome of the inspection concluded that the areas for improvement from the last inspection had been addressed and no new areas for improvement were identified.

Based on the inspection findings and discussions held, RQIA 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 regarding the management of medicines.

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

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. The inspection was completed by examining 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. Discussions were held about how staff and management plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with nursing staff and the management team. 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.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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 responses 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 the last inspection?

| Areas for improvement from the last inspection on 25 July 2023 | | |
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| Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 | | Validation of compliance |
| Area for improvement 1 Ref: Regulation 13 (4) Stated: First time | The registered person shall review the management of medicines administered via the enteral route as detailed in the report. Records of each patient's daily nutrition regimen should be available and daily fluid intake records should be accurately maintained. | Met |

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| | <p>Action taken as confirmed during the inspection: This area for improvement was assessed as met. See section 5.2.1.</p> | |
| <p>Area for improvement 2 Ref: Regulation 13 (4) Stated: First time</p> | <p>The registered person shall ensure that records of medicines received into the home are accurately maintained in order to provide a clear audit trail.</p> <p>Action taken as confirmed during the inspection: This area for improvement was assessed as met. See section 5.2.1.</p> | Met |
| <p>Area for improvement 3 Ref: Regulation 13 (4) Stated: First time</p> | <p>The registered person shall review the management of warfarin to ensure that dosage directions are received in writing.</p> <p>Action taken as confirmed during the inspection: The dosage directions for warfarin were received in writing and transcribed by two nurses to ensure accuracy. This area for improvement was assessed as met.</p> | Met |
| <p>Area for improvement 4 Ref: Regulation 13 (4) Stated: First time</p> | <p>The registered person shall review the management of medicines on admission to ensure that:</p> <ul style="list-style-type: none"> • an accurate list of currently prescribed medicines is received from the hospital or GP to ensure that medicines are administered in accordance with the most recent directions • hand-written medication administration records are verified and signed by two nurses to ensure accuracy of transcription • the quantity of each medicine received into the home is accurately recorded to provide a clear audit trail. <p>Action taken as confirmed during the inspection: This area for improvement was assessed as met. See sections 5.2.1, 5.2.3 and 5.2.4.</p> | Met |

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| Area for improvement 5 Ref: Regulation 14 (2) (a) (c) Stated: Second time | The registered person shall ensure all parts of the home that patients have access to are free from hazards. This is stated in relation to the safe and secure storage of cleaning chemicals when not in use. | Met |
| | Action taken as confirmed during the inspection: No cleaning chemicals were observed to be stored inappropriately. The manager confirmed that storage has been reviewed, staff have completed COSHH training and the importance of the safe storage of cleaning chemicals has been discussed with staff; and that compliance is checked daily by the manager/nurse in charge. | |
| Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022 | | Validation of compliance |
| Area for improvement 1 Ref: Standard 28 Stated: First time | The registered person shall implement a robust audit system which includes all aspects of the management of medicines. | Met |
| | Action taken as confirmed during the inspection: This area for improvement was assessed as met. See section 5.2.3. | |

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 may 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 member of staff had checked and signed the personal medication records when they were written and updated to state 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. Records of incoming medicines were well maintained and facilitated audit.

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 records; and care plans 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. Records included the reason for and outcome of each administration on the occasions when these medicines were used.

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 and pain assessments 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 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. 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.

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 on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

5.2.2 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.

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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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

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.

A sample of the medicine administration records was reviewed and these were found to have been accurately completed. Hand-written additions to medication administration records were verified and signed by two nurses to ensure accuracy of transcription. The records were filed once completed and were readily retrievable for audit.

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. The date of opening was recorded on medicines so that they could be easily audited. This is good practice.

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.

There had been no recent admissions to the home. However, the admission process for new patients or patients returning from hospital was reviewed. Robust arrangements were in place to ensure that a current list of the patient's medicines was obtained and shared with the community pharmacist.

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. 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.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

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 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.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

No new areas for improvement were identified during this inspection. Findings of the inspection were discussed with Mr Martin Kelly, Registered Manager, as part of the inspection process and can be found in the main body of the report.



The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
Twitter @RQIANews

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