

Inspection Report

18 April 2024



Queenscourt

Type of service: Nursing Home
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Manor Healthcare Ltd Responsible Individual: Mr Eoghain King	Registered Manager: Mr Martin Yeo, registration pending.
Person in charge at the time of inspection: Mr Martin Yeo, manager	Number of registered places: 43
Categories of care: Nursing (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: 29
Brief description of the accommodation/how the service operates: Queenscourt is a nursing home which is registered to provide care for up to 43 patients who are living with a learning disability.	

2.0 Inspection summary

An unannounced inspection took place on 18 April 2024, from 10:50am to 3.00pm. 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.

Progress with the areas for improvement identified at the last medicines management inspection were reviewed. The area for improvement identified at the last care inspection will be followed up at the next care inspection.

Review of medicines management found that 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 areas for improvement identified at the last medicines management inspection had been addressed. One new area for improvement was identified regarding the disposal of controlled drugs; details can be found in the Quality Improvement Plan.

Whilst an area for improvement was identified, RQIA can conclude that the patients were being administered their medicines as prescribed.

RQIA would like to thank the 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. Nurses and the manager stated they had worked hard to improve the management of medicines.

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 22 February 2024		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 20 (1) (c) (i) Stated: First time	The registered person shall ensure that all staff have a recorded annual appraisal.	Carried forward to the next inspection
	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.	

Areas for improvement from the last medicines management inspection on 3 June 2021		
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 ensure that personal medication records are accurate and up to date at all times and reflect the prescriber's most recent instructions.	Met
	Action taken as confirmed during the inspection: This area for improvement was assessed as met. See section 5.2.1.	
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		Validation of compliance
Area for improvement 1 Ref: Standard 28 Stated: First time	The registered person shall ensure that the date of opening is recorded on all medicines to facilitate audit and prevent administration after expiry.	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, one observed discrepancy was highlighted and addressed immediately. 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.

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 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 and nutritional supplements were 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.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside the recommended range.

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. It was agreed that inhaler spacer devices would be stored covered for infection prevention and control purposes.

Mostly satisfactory arrangements were in place for the disposal of medicines, however the disposal of of Schedule 4 (Part 1) controlled drugs must be reviewed; see section 5.2.3.

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 medicines administration records was reviewed and were found to have been accurately completed. A small number of missed signatures were observed and brought to the attention of the manager for monitoring. 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 should be recorded in the controlled drug record book. There were mostly satisfactory arrangements in place for the management of controlled drugs, however there was evidence that Schedule 4 (Part 1) controlled drugs such as benzodiazepines were not being denatured prior to disposal as per legislative requirements and the home's standard operating procedures for controlled drugs. An area for improvement was identified.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Written consent and care plans were in place when this practice occurred.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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

One new area for improvement has been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	1*	1

* The total number of areas for improvement includes one which is carried forward for review at the next inspection.

The new area for improvement and details of the Quality Improvement Plan were discussed with Mr Martin Yeo, Manager, as part of the inspection process. The timescale for completion commences 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 20 (1) (c) (i) Stated: First time To be completed by: With immediate effect (10 and 11 May 2023)	The registered person shall ensure that all staff have a recorded annual appraisal. 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. Ref: 5.1
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022	
Area for improvement 1 Ref: Standard 28 Stated: First time To be completed by: With immediate effect (18 April 2024)	The registered person shall ensure that all controlled drugs in Schedule 4 (Part1), are denatured and rendered irretrievable before being placed in waste containers. Ref: 5.2.3 Response by registered person detailing the actions taken: Home manager has supported nursing staff and re-educated them of correct denaturing of schedule 4 medications. To aid staff a reminder has been placed in the medication destruction book. Home manager has updated the Staff Nurse induction booklet to make it more clear for new staff starting.

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