The Regulation and Quality Improvement Authority

Inspection Report

28 May 2024

Marina Care Home

Type of service: Nursing Home
Address: Shore Road, Ballyronan, BT45 6JA
Telephone number: 028 7941 8770

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

1.0 Service information

Organisation: Burnview Healthcare Ltd **Responsible Individual:** Mrs Briege Agnes Kelly	**Registered Manager:** Mrs Una McTaggart **Date registered:** 11 November 2016
Person in charge at the time of inspection: Mrs Una McTaggart	**Number of registered places:** 32
Categories of care: Nursing Home (NH) I – old age not falling within any other category.	**Number of patients accommodated in the nursing home on the day of this inspection:** 28
Brief description of the accommodation/how the service operates: Marina Care Home is a registered nursing home which provides nursing care for up to 32 patients. Patient bedrooms are located over two floors. Patients have access to communal lounges, a dining room and outside spaces.	

2.0 Inspection summary

An unannounced inspection took place on 28 May 2024, from 10.00am to 1.30pm. 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 area for improvement identified at the last care inspection has been carried forward for follow up at the next care inspection.

Review of medicines management found that medicines were stored safely and securely. 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. One new area for improvement in relation to the maintenance of the personal medication records was identified.

Whilst one area for improvement was identified, it was concluded that overall, with the exception of a small number of medicines, 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 with staff and management about how they plan, deliver and monitor the management of medicines.

4.0 What people told us about the service

The inspector met with nursing staff and the manager. Staff interactions with patients were warm, friendly and supportive. It was evident 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.

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.

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 3 October 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that RQIA is appropriately notified of any accident in the home where medical advice is sought.	**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.	

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 was identified that some of these records were not up to date with the most recent prescription. Discrepancies were identified between the directions on the personal medication records and the dosage signed as administered on the medicine administration records. Assurances were provided that the medicines had been administered in accordance with the most recent directions. However, if the personal medication records are not accurate and up to date, this could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional.

The manager gave an assurance that all patients' personal medication records would be reviewed and updated accordingly following the inspection. An area for improvement was identified.

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. Records included the reason for and outcome of each administration.

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. However, a small number of discrepancies between the consistency recommended in the speech and language assessment report and the consistency stated on the personal medication records were identified. This was highlighted to the manager and assurances were provided that the correctly prescribed consistency of fluids were being administered. As stated above, an area for improvement in relation to the maintenance of personal medication records was identified.

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. Nurses were reminded to consistently record the date of opening on in-use insulin pen devices in order to facilitate audit and disposal upon expiry.

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 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. Temperatures of the 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 medicines administration records was reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. The records were filed once completed and readily retrievable for audit/review.

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.

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 the large majority of 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 incident which had been reported to RQIA since the last inspection was discussed. There was evidence that the incident 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 the 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.

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 Quality Improvement Plan/Areas for Improvement

One 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 has been carried forward for review at the next inspection.

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Una McTaggart, Registered 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 30 **Stated:** First time **To be completed by:** With immediate effect (3 October 2023)	The registered person shall ensure that RQIA is appropriately notified of any accident in the home where medical advice is sought. **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 29 **Stated:** First time **To be completed by:** With immediate effect (28 May 2024)	The registered person shall ensure that fully complete and accurate personal medication records are maintained. Ref: 5.2.1 **Response by registered person detailing the actions taken:** All residents personal medication records were reviewed and updated according to the prescription. The Speech and Language therapy recommendations on personal medication records were also reviewed and updated. Clinical supervision has been carried out for all the nurses regarding the maintenance of medication records, to ensure the accuracy and completion of the same.

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