The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Drombane**

Provider: **Mrs Elizabeth Kathleen Mary Lisk**

Date of Inspection: **22 May 2025**

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

1.0 Service information

Registered Provider:	Mrs Elizabeth Kathleen Mary Lisk
Responsible Person:	Mrs Elizabeth Kathleen Mary Lisk
Registered Manager:	Mrs Daizy Samuel
Service Profile: Drombane is a registered nursing home which provides nursing care for up to 20 patients. Patient bedrooms are located over two floors. Patients have access to communal lounges, a dining room and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 22 May 2025, from 10.15am to 1.30pm. 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 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. Medicines were stored securely. 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. However, improvements were necessary in relation to recording medication room temperatures and the management of admissions/readmissions.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, patients were being administered their medicines as prescribed.

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.

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

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

Eight questionnaires were received from patients who were very satisfied with how their medicines were managed. Comments included: 'I am happy here, all the nurses are good with me'.

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.

Staff 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.

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.

Most 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. One personal medication record was not updated following the readmission of a patient from hospital. This was discussed with the nurse in charge and manager for follow up and action. See section 3.3.4.

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 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.

The management of distressed reactions, pain, thickening agents and warfarin were reviewed. Care plans contained sufficient detail to direct the required care. The audits completed indicated that medicines were administered as prescribed.

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. 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 number of scoops was recorded on one personal medication record and one administration record rather than the consistency level. One administration record did not have the consistency level recorded.

The manager was reminded to ensure the consistency level is recorded on all personal medication records and administration records and assurance was provided that this would be updated immediately.

There was improvement in relation to the management of insulin identified at the previous medication inspection on 30 June 2022. Satisfactory arrangements were in place for the management of insulin. Care plans were in place when patients required insulin to manage their diabetes. The manager was reminded to include details in the care plans to direct staff if the patient's blood sugar was outside of the recommended range. Assurance was provided this would be updated immediately.

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 area was observed to be securely locked to prevent any unauthorised access. It was organised so that medicines belonging to each patient could be easily located. Satisfactory arrangements were in place for the storage of controlled drugs and the safe disposal of medicines.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C 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. Records reviewed suggested that the thermometer was not always reset. This was highlighted to the manager for ongoing monitoring.

Medicines must be stored at the manufacturers' recommended temperature in order to ensure their stability and efficacy; this is usually at or below 25^{o}C for medicines recommended to be stored at room temperature. Review of records indicated that the daily treatment room temperature was not recorded. An area for improvement was identified.

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. Records were found to have been accurately completed. Records were filed once completed and were 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.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

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.

The arrangements in place to manage medicines at the time of admission or for patients returning from hospital were reviewed. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. One readmission was reviewed and evidenced that the personal medication record had not been reviewed or updated following hospital discharge. Discrepancies were identified in the dose of two medicines. This was discussed with the nurse in charge and the manager for review and follow up. An area for improvement was identified.

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.

There had been no medicine related incidents reported to RQIA since the last medicines management inspection. Management and staff were familiar with the type of incidents that should be reported. The inspector signposted staff to the RQIA provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the nurses on duty and the manager for on-going monitoring.

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.
There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Competency had been assessed following induction and annually thereafter. 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*	2*

* the total number of areas for improvement includes 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 Daizy Samuel, 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:** First time **To be completed by:** 22 May 2025	The registered person shall ensure during the readmission process that personal medication records are reviewed and updated and where discrepancies are identified these are followed up in a timely manner. Ref: 3.3.1 and 3.3.4
	Response by registered person detailing the actions taken: staff nurse always reviewed discharge letter with kadex after readmission. however, this instance, no discharge letter was received due to encompass and upon ringing the hospital and G.P., both stated there is no change in medication and to continue with the same medications.
Area for improvement 2 **Ref:** Regulation 13 (1) (a) **Stated:** Second time **To be completed by:** 31 August 2024	The registered person shall ensure that neurological observations are accurately and consistently recorded in line with best practice guidance.
	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: 2.0
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 22 May 2025	The registered person shall ensure that the room temperature of the medication storage area is monitored daily and records maintained. Ref: 3.3.2
	Response by registered person detailing the actions taken: The room temperature is monitored daily by the staff and is still an ongoing process. Temperature record always recorded by staff nurse on shift.

Area for improvement 1 **Ref:** Standard 38 **Stated:** First time **To be completed by:** 20 August 2024	The registered person shall ensure gaps in employment are expected in full before staff commence working in the home.
	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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