The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Hillcrest Care Facility**

Provider: **Dunluce Healthcare Omagh Ltd**

Date of Inspection: **15 October 2024**

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:	Dunluce Healthcare Omagh Ltd
Responsible Individual:	Mr Ryan Smith
Registered Manager:	Miss Lauren McGaghran

Service Profile

Hillcrest Care Facility is a registered nursing home which provides nursing care for up to 59 patients. The home is split into three units over two floors. Hillview unit accommodates 20 patients, Primrose unit 19 patients and Sunflower unit 20 patients.

There is a residential care home which occupies the first and second floors. This service is managed by a different registered manager, with shared ancillary arrangements.

2.0 Inspection summary

An unannounced inspection took place on 15 October 2024, from 10.10 am to 4.30 pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

Review of medicines management found that medicines were stored safely and securely. Staff had received training and competency assessment on the management of medicines.

As a result of this inspection, two new areas for improvement in relation to the management of medicines for distressed reactions and maintenance of personal medication records were identified. Whilst areas for improvement were identified, there was evidence that patients were being administered their medicines as prescribed.

Areas for improvement identified at the last care inspection will be reviewed at the next inspection. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in 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 the RQIA inspector will seek to speak with patients, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home.

Through actively listening to a broad range of patients, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service and their quality of life

The inspector spoke with a range of staff and management to seek their views of working in the home.

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. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the deputy 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.

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.

Some records were not up to date with the most recent prescription and some were not signed by two members of staff to ensure accuracy. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. The discrepancies were discussed with the deputy manager who provided assurances the identified records would be updated immediately 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 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 and records of administration included the reason for and outcome of each administration. However, care plans directing the use of these medicines were not in place for all of the patients reviewed. 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.

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. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained. One discrepancy between the consistency level recorded in the personal medication record and the care plan was identified. This was highlighted to nursing staff during the inspection for correction. Review of the administration record highlighted the correct consistency of fluids were being administered.

The management of insulin was reviewed. 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 of the recommended range. It was identified that some in-use insulin pen devices were not individually labelled and the date of opening had not been recorded. This is necessary to facilitate audit and disposal upon expiry. This was discussed with the deputy manager who provided assurances that this would be rectified following the inspection and included in the home's audit process moving forward.

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. Although blood tests had been carried out at the identified times and warfarin had been administered as prescribed, a patient specific care plan was not in place. Assurances were provided that a patient specific care plan would be implemented.

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 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 medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

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

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 fully and accurately completed. A small number of minor discrepancies were highlighted to staff for ongoing close monitoring. 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.

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 plan. Written consent and care plans were in place when this practice occurred.
Care plans contained sufficient detail to describe how the patient's medicines were administered.

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.

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

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. 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 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.

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. Ongoing review was monitored through supervision with staff and at annual appraisal. Medicines management policies and procedures were in place.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1*	4*

* the total number of areas for improvement includes three which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Tara Pollock, Deputy 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 27 (2) (q) **Stated:** First time **To be completed by:** 24 August 2024	The registered person must submit a time bound action plan detailing the actions taken in response to the recommendations made in the electrical service report, dated 12 June 2023. This action plan needs to be submitted to the home's aligned estates inspector. **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.**
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:** From the date of inspection (15 October 2024)	The registered person shall ensure that care plans are in place when medicines are prescribed for the management of distressed reactions. Ref: 3.3.1 **Response by registered person detailing the actions taken:** The Registered Manager has ensured that all care plans are in place when medicines have been prescribed for the management of distressed reactions.
Area for improvement 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** From the date of inspection (15 October 2024)	The registered person shall ensure that personal medication records are accurately maintained and verified by two members of staff to ensure accuracy. Ref: 3.3.1 **Response by registered person detailing the actions taken:** The Registered Manager has ensured that all personal medication records have been accurately maintained and verified by two members of staff.

Area for improvement 3 **Ref:** Standard 11 (14) **Stated:** First time **To be completed by:** 24 August 2024	The registered person shall ensure patients' spiritual care needs and contact details are improved in detail in their care records.
	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.
Area for improvement 4 **Ref:** Standard 1 (7) **Stated:** First time **To be completed by:** 24 August 2024	The registered person shall put in place provision for the identified piece of equipment for patients' needs.
	Action required to ensure compliance with this standardwas not reviewed as part of this inspection and this is carried forward to the next inspection.

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The Regulation and Quality Improvement Authority

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