Inspection Report

31 March 2022

Jason Court

Type of service: Nursing Home
Address: 375 North Queens Street, Belfast, Co Antrim, BT15 1HT
Telephone number: 028 9694 7088

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: Healthcare Ireland (Belfast) Limited **Responsible Individual:** Ms Andrea Louise Campbell	**Registered Manager:** Ms Lavina Ann Harris **Date registered:** 31 August 2021
Person in charge at the time of inspection: Ms Lavina Ann Harris	**Number of registered places:** 59
Categories of care: Nursing (NH): PH – physical disability other than sensory impairment MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years PH(E) - physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 58

Brief description of the accommodation/how the service operates:

This home provides nursing care and support for up to 59 people. The service provides physical, psychological and social support to patients with mental health needs or patients with an acquired brain injury.

The home operates over three floors. Patient accommodation is located on the ground and first floor. There is a variety of accommodation ranging from single, en-suite bedrooms, to two roomed suites comprising an en-suite shower room with adjoining bedroom and living room space. A number of rooms have private outside space which patients access from their own room.

The kitchen, laundry and staff changing facilities are located on the second floor; access to this floor is restricted to staff.

2.0 Inspection summary

An unannounced inspection took place on 31 March 2022, from 10.15am to 3.45pm. This was completed by a pharmacist and a finance inspector.

The inspection focused on medicines management and patient finances 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 and patient finances.

Review of medicines management found generally good 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. One new area for improvement was identified in relation to the completion of fluid balance charts.

RQIA received information during March 2022 which raised concerns in relation to the management of patient finances. In response to this information RQIA decided to undertake an inspection.

Some of the controls surrounding the systems for managing patients' finances and personal property required strengthening within the home. Following the RQIA inspection Healthcare Ireland Ltd submitted a report to RQIA providing assurances that new systems had been implemented to improve the controls within the home. These systems will be reviewed at the next RQIA inspection. One new area for improvement was identified in relation to recording the checks of patients' personal property.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

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 manager/management team

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 medicines management 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. Staff and patients views were also obtained.

The finance inspection was completed by reviewing a sample of patients' financial and property records, the systems for retaining and distributing patients' monies and property and the audit systems for the management of patients' finances and property.

4.0 What people told us about the service

Patients were observed to be relaxing in their bedrooms or in the communal areas of the home. Patients were relaxed and staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

The inspectors also met with nursing staff and management. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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 17 November 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 Ref: Regulation 27(4)(a) Stated: First time	The Registered Person shall ensure that when the identified equipment is fitted the fire risk assessment is updated prior to the bedroom being occupied.	**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.	
Area for improvement 2 Ref: Regulation 12(1)(a)	The Registered Person shall ensure that the smoking arrangements between 11pm and 8am are individually risk assessed and managed.	**Carried forward to the next inspection**

Stated: First time	**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 Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for improvement 1 Ref: Standard 18.7 Stated: First time	The registered person shall ensure that the audit of restraint is further developed to include the incidence of physical restraint. The audit should review each circumstance, proportionality and that interventions were completed in accordance with the patients' care plan.	**Carried forward to the next inspection**
	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.	

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.

A small number of obsolete personal medication records had not removed from the medicines file and archived. Staff were reminded that this is necessary to ensure that nurses do not refer to obsolete directions in error and administer medicines incorrectly to the patient.

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 the management of 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 cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. The management of medicines and nutrition via the enteral route for one patient was reviewed. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement were completed, however the total fluid intake was not documented on daily fluid intake charts. This is necessary to ensure the patients' recommended daily fluid intake is achieved and to facilitate monitoring and review. An area for improvement was identified.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines 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. The medicine trolleys were tidy and organised so that medicines belonging to each patient could be easily located.

Storage space for bulkier medicine items was limited in some of the treatment rooms and the home would benefit from having additional shelving or cupboards to store larger items. This was discussed with the manager.

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. The disposal of Schedule 3 and 4 (part1) controlled drugs was discussed. Staff were reminded that disposal records should document that these medicines had been denatured prior to disposal.

Staff were reminded that the key for the controlled drugs cabinet should be held separately from all other keys.

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. Staff were reminded that codes to indicate non-administration of a medicine should be circled to differentiate them from staff initials. 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 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 all 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 helps 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. One discrepancy was highlighted to the manager for monitoring.

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.

5.2.7 What arrangements are in place to ensure that patients' monies, valuables and personal property are appropriately managed and safeguarded?

Discussion with the manager confirmed that patients' monies were held for safekeeping within each of the units of the home and that patients made their own purchases. A review of a sample of monies held for five patients evidenced that all but one of the amounts agreed to the record of the amounts held. No explanation was provided during the inspection in relation to the variance for one patient. Following the inspection Healthcare Ireland Ltd carried out an audit of patients' finances on 5 and 6 April 2022. A copy of the report from the audit was forwarded to RQIA prior to issuing this inspection report. The report stated that all patients' monies had been checked since the RQIA inspection and no discrepancies were found during the audit.

Discussion with the manager confirmed that patients' monies were received from Healthcare Ireland's bank account and subsequently distributed to each of the units. No records were available to show the amount received from the bank account and the corresponding amount distributed to the units. The audit report forwarded to RQIA following the inspection states that a procedure is now in place for recording the monies. This procedure will be reviewed at the next RQIA inspection.

A number of patients' personal items were held in the safe place within each unit, no records were available detailing the items held for safekeeping. The Healthcare Ireland audit report states that a new system for retaining and distributing patients' monies and personal property has been implemented following the RQIA inspection. Healthcare Ireland has provided assurances that this system will improve the controls surrounding patients' finances and personal property. The revised system will be reviewed at the next RQIA inspection.

Copies of four patients' written agreements were reviewed. The agreements set out the terms and conditions for residing at the home and were signed by the patients, or their representatives, and a representative from the home. The agreements showed the current weekly fee paid by, or on behalf of, the patients.

Review of records and discussion will staff confirmed that all patients' weekly fees were paid to Healthcare Ireland by the Health and Social Care Trusts. Staff also confirmed that no patient was paying an additional amount towards their fee over and above the amount agreed with the Health and Social Care Trusts.

Discussions with the manager confirmed that no member of staff was the appointee for any patient, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

Discussion with staff confirmed that a vehicle, owned by Healthcare Ireland was available for patients to undertake journeys. Patients were not charged for these journeys.

A sample of two patients' files evidenced that property records were in place for both patients. There was no evidence that the records were checked and signed by two members of staff at least quarterly. This was identified as an area for improvement.

Policies and procedures for the management and control of patients' finances were available for inspection. The policies were readily available for staff use. A review of the policies evidenced that they reflected the operational areas for managing patients' finances. The policies were up to date and reviewed at least every three years.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and or the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	2*	3*

* 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 Ms Lavina Harris, Registered Manager and the regional manager for Healthcare Ireland (Belfast) Limited, 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(4)(a) **Stated:** First time **To be completed by:** At the time of fitting the equipment.	The Registered Person shall ensure that when the identified equipment is fitted the fire risk assessment is updated prior to the bedroom being occupied. Ref: 5.2.3 **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
Area for improvement 2 **Ref:** Regulation 12(1)(a) **Stated:** First time **To be completed by:** 25 November 2021	The Registered Person shall ensure that the smoking arrangements between 11pm and 8am are individually risk assessed and managed. Ref: 5.2.4 **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, April 2015	
Area for improvement 1 **Ref:** Standard 18.7 **Stated:** First time **To be completed by:** 17 December 2021	The registered person shall ensure that the audit of restraint is further developed to include the incidence of physical restraint. The audit should review each circumstance, proportionality and that interventions were completed in accordance with the patients' care plan. **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: 5.1
Area for improvement 2 **Ref**: Standard 12 **Stated:** First time **To be completed by:** From the date of inspection onwards (31 March 2022)	The registered person shall ensure that fluid balance charts are fully completed and totalled every day to ensure that the target fluid intake is monitored. Ref: 5.2.1 **Response by registered person detailing the actions taken:** This has been addressed.The fluid balance charts are being fully completed and totalled every 24 hours to ensure that the target fluid intake is monitored.The charts are then being spot

	checked by the Deputy and Registered Manager.
Area for improvement 3 **Ref:** Standard 14.26 **Stated:** First time	The registered person shall ensure that the records of patients' personal possessions are checked at least quarterly and signed by two members of staff. Ref: 5.2.7
To be completed by: 31 May 2022	**Response by registered person detailing the actions taken:** This has been addressed.There is a record of each patient's personal possessions on file and these are being checked and updated at least quarterly and signed by two members of staff.The file has been checked by the Regional Manager.

Please ensure this document is completed in full and returned via the Web Portal

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