Inspection Report

18 October 2022

Ailsa Lodge

Type of service: Nursing Home
Address: 6 Killaire Avenue, Carnalea, Bangor, BT19 1EW
Telephone number: 028 9145 2225

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: Merit Homes Ltd **Responsible Individual:** Ms Therese Elizabeth Conway	**Registered Manager:** Mrs Janet Davison **Date registered:** 7 December 2020
Person in charge at the time of inspection: Mrs Janet Davison	**Number of registered places:** 42
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 39
Brief description of the accommodation/how the service operates: Ailsa Lodge is a nursing home which is registered to provide nursing care for up to 42 patients.	

2.0 Inspection summary

An unannounced medicines management and finance inspection took place on 18 October 2022 from 9.55 am to 4.40pm. The inspection was completed by a pharmacist inspector and a finance inspector.

The inspection focused on medicines management and the management of patients' finances within the home and also assessed progress with the area for improvement identified at the last care inspection.

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 the management of patients' finances.

The outcome of the inspection in relation to medicines management concluded that medicines were stored safely and administered as prescribed. The majority of medicine related care plans and records were well maintained. However, three areas for improvement were identified in

relation to the medicines administration process, records of administration and the management of medicines which are self-administered.

With regards to finance, adequate controls surrounding patients' finances were in place. Patients' financial records were up to date at the time of the inspection. No new areas for improvement were identified.

RQIA would like to thank the patients and 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.

In relation to finance, a sample of patients' financial files which included records of transactions and patients' personal property were reviewed. Controls surrounding the management of patients' monies and property were also reviewed.

4.0 What people told us about the service

The inspectors met with two nurses, the home administrator and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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 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 patients 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.

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 28 June 2021		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 4.8 **Stated:** First time	The registered persons shall ensure that care plans for behaviours which challenge contained details of how the patients' behaviours presented, any known triggers and what approaches helped to calm them.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met.	

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 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.

The personal medication records reviewed at the inspection were accurate and up to date. In line with safe practice, a second member of staff had checked and signed the personal medication records when they were written to confirm they were accurate. Nurses were reminded that all updates should also be verified and signed by a second nurse to ensure accuracy.

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.

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 for three patients. Directions for use were clearly recorded on the personal medication records. 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, infection or constipation. Records of administration included the reason for and outcome.

The management of pain was reviewed for two patients. Each patient had a pain management care plan and their medicines had been administered as prescribed. Regular pain reviews were completed.

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 for two patients. Speech and language assessment reports and care plans were in place. Records of prescribing and administration included the recommended consistency level. The manager advised that thickening agents were always administered under the direct supervision of the nursing staff.

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 their target range.

A small number of patients self-administer some of their prescribed medicines. Care plans were not in place and records of the transfer of the medicines for self-administration were not maintained. 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. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas and medicines refrigerators were monitored and recorded to ensure that medicines were stored appropriately.

Appropriate arrangements were in place for the disposal of medicines.

5.2.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important that nurses follow safe medication administration processes to ensure that medicines are administered to the right patient at the right time and the appropriate records are maintained. This includes administering medicines to each patient directly from their dispensed supply and signing the record of administration immediately after the medicine has been administered to the specific patient. Failure to follow this process may mean that medicines are administered to the wrong patient in error and records of administration are not accurately maintained.

The inspector observed the lunchtime medicines being prepared for five patients at the same time. Records of administration were signed for all five patients prior to administration. This practice is unsafe and increases the likelihood of a medication error. Nurses must follow safe processes for the administration of medicines. An area for improvement was identified.

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. Whilst the majority had been accurately maintained, there were a significant number of missed signatures. The audits completed by the inspector indicated that the medicines had been administered as prescribed but that the records of administration had not been signed. Records of administration must be accurately maintained. An area for improvement was identified.

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 controlled drug record books. Records had been maintained to the required standard. There were satisfactory arrangements in place for the management of controlled drugs.

Management and staff audited the management and administration of medicines on a monthly basis. In addition, running stock balances were maintained for medicines which were not supplied in the monitored dosage sachets, including inhaled medicines. The date of opening was recorded on all medicines so that they could be easily audited. The audits completed at the inspection indicated that medicines were administered as prescribed. A small number of discrepancies were discussed with the manager for ongoing close monitoring.

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 patients new to the home 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 and the medicines had been administered as prescribed.

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 learning shared with staff in order to prevent a recurrence.

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 staff are competent in managing medicines and they are supported. Policies and procedures should be up to date and readily available.

Records of staff training and competency assessment in relation to medicines management were available. The staff training matrix was reviewed monthly by the manager to ensure that all staff were up to date with their training, competency assessments and appraisals.

It was agreed that the findings of the inspection would be discussed with staff to drive ongoing improvement.

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

A safe place was provided within the home for the retention of patients' monies and valuables. At the time of the inspection there were satisfactory controls around the physical location of the safe place and the members of staff with access to it. Records of patients' monies and valuables held at the home were up to date at the time of the inspection.

Comfort fund monies were held on behalf of patients, these are monies donated to the home for the benefit of all patients. A review of a sample of transactions from the fund confirmed that records were up to date and that purchases were for the benefit of all patients. Discussion with staff confirmed that no bank accounts were used to retain patients' monies.

A sample of records evidenced that reconciliations (checks) of monies held on behalf of patients were undertaken on a monthly basis. The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

Three patients' finance files were reviewed; copies of written agreements were retained in all three files. The agreements included the details of the current weekly fee paid by, or on behalf of, the patients and a list of services provided to patients as part of their weekly fee. A list of services available to patients at an additional cost, such as hairdressing, was also included. The agreements were signed by the patient, or their representative, and a representative from the home.

A sample of records of fees received for one patient evidenced that the amounts received were in line with the amounts owed by the patients. Discussion with staff 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.

Discussion with staff confirmed that no member of staff was an 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.

A sample of purchases undertaken on behalf of patients was reviewed. The records were up to date at the time of the inspection. Two signatures were recorded against each entry in the patients' records and receipts were available from each of the purchases reviewed. In line with good practice signed authorisation forms for holding patients' monies and undertaking purchases on behalf of patients were included in the patients' files. A sample of signatures of members of staff authorised to undertake transactions, on behalf of patients, was also retained within the files.

A sample of records of payments to the hairdresser was reviewed. These records were up to date and signed by the hairdresser. The records were countersigned by a member of staff to confirm that the treatments took place.

A sample of records of monies deposited at the home on behalf of a patient was reviewed. Records were up to date at the time of the inspection. Receipts were provided to the person depositing the monies on behalf of the patient.

A sample of two patients' files evidenced that property records were in place for both patients. There was no evidence that records were updated with additional items brought into patients' rooms or that the records were reconciled at least quarterly. Discussions with the manager confirmed that a new system for recording and checking patients' personal possessions was being implemented and should be in place by 30 November 2022. This will be reviewed at the next RQIA inspection.

Policies and procedures for the management and control of patients' finances and property were available for inspection. The policies were readily available for staff use. The policies were up to date and reviewed at least every three years.

Records of staff training in relation to patient's finances were available for inspection. Staff involved with patients' finances had received adult safeguarding training.

Discussion with staff confirmed that no transport scheme was in place at the time of the inspection.

No finance related areas for improvement were identified during the inspection.

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 the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	2	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Janet Davison, 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:** From the date of inspection	The registered person shall ensure that nurses follow safe processes for the administration of medicines. Ref 5.2.3
	Response by registered person detailing the actions taken: Recorded discussion and supervision completed with all nursing staff to reinforce the processes for the safe administration of medication. In-house refresher medication training scheduled to be delivered by the community pharmacist. Increased observational auditing implemented throughout medication administrations to ensure compliance with safe practices.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that medication administration records are accurately maintained. Ref: 5.2.3
	Response by registered person detailing the actions taken: Supervision completed with all nursing staff to reiterate the importance of accurate and contemporaneous medication administration records. Increased auditing implemented to monitor and improve medication administration recording.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 18 November 2022	The registered person shall review and revise the management of medicines which are self-administered. Care plans should be in place and records of transfer of medicines to the patient should be maintained. Ref: 5.2.1
	Response by registered person detailing the actions taken: Care plans devised in partnership with the resident to demonstrate the correct management of self administered medications. Records for transfer of medications to the resident implemented and in place. Nursing Staff all aware of the policy and procedure relating to the management of self administered medications

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