

Inspection Report

27 April 2023



Ambassador

Type of service: Nursing Home
Address: 462-464 Antrim Road, Belfast, BT15 5GE
Telephone number: 028 9077 1384

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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: Amstecos Ltd	Registered Manager: Mrs Amelia Noach
Responsible Individual: Mrs Emer Bevan	Date registered: 1 April 2005
Person in charge at the time of inspection: Mr Ray Wilson, Registered Nurse	Number of registered places: 48 This number includes a maximum of two patients in category NH-A.
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 A – past or present alcohol dependence TI – terminally ill	Number of patients accommodated in the nursing home on the day of this inspection: 43
Brief description of the accommodation/how the service operates: Ambassador is a nursing home registered to provide nursing care for up to 48 patients. Patients' bedrooms are located over three floors. Patients have access to communal lounges, a dining room and a garden area at the rear of the home.	

2.0 Inspection summary

An unannounced inspection took place on 27 April 2023, from 10.30am to 3.00pm. 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 areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection.

Review of medicines management found that robust 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 and staff were trained and competent to manage medicines. No new areas for improvement were identified.

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 management team regarding the management of medicines.

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. The inspector spoke with staff about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with nursing staff and a nurse support worker. 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 interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

Feedback methods included a staff poster and paper questionnaires which were provided for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, one questionnaire had been returned from a relative of a patient who was very satisfied with the care provided.

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 care inspection on 10 November 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for Improvement 1 Ref: Regulation 13 (1) (a) (b) Stated: Second time	The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record.	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 14 (2) (a) Stated: First time	The registered person shall ensure that all parts of the home to which patients have access are free from hazards to their safety.	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 3 Ref: Regulation 27 (4) (c) Stated: First time	The registered person shall provide adequate means of escape by ensuring combustible items are not inappropriately stored under stairwells.	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 4 Ref: Regulation 30 Stated: First time	The registered person shall ensure that appropriate notifications are submitted to RQIA without delay. This relates specifically to unwitnessed falls within the home.	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.	
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for Improvement 1 Ref: Standard 38 Stated: First time	The registered person shall ensure that records regarding staff registration with the NISCC are at all times available for inspection in the home by any person authorised by the RQIA.	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.	
Area for improvement 2 Ref: Standard 21 Stated: First time	The registered person shall ensure that accidents, incidents are reported to relevant bodies, specifically the residents' General Practitioner (GP) in accordance with legislation and procedures in relation to unwitnessed falls and a record is maintained.	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 mostly accurate and up to date. Two minor discrepancies were highlighted to nurses and were rectified immediately. 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.

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 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. Nurses stated that these medicines were rarely if ever administered but that the reason for and outcome of each administration would be recorded for 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 administration which included the recommended consistency level were maintained. Nurses were reminded that records of prescribing must always include the consistency level.

The management of warfarin was reviewed. Warfarin is a high risk medicine and safe systems must be in place to ensure that patients are administered the correct dose and arrangements are in place for regular blood monitoring. Review of the warfarin administration records and audits completed at the inspection identified satisfactory arrangements were in place.

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 area was observed to be securely locked to prevent any unauthorised access. It was 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. 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. All of the records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for 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 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.

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 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 the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines which were highlighted to the nurse in charge for close 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.

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.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	4*	2*

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

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mr Ray Wilson, Registered Nurse, and Ms Sarah Boyd, Nurse

Support Worker, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (1) (a) (b) Stated: Second time To be completed by: Immediate action required (10 November 2022)	<p>The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record.</p> <p>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.</p> <p>Ref: 5.1</p>
Area for improvement 2 Ref: Regulation 14 (2) (a) Stated: First time To be completed by: Immediate action required (10 November 2022)	<p>The registered person shall ensure that all parts of the home to which patients have access are free from hazards to their safety.</p> <p>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.</p> <p>Ref: 5.1</p>
Area for improvement 3 Ref: Regulation 27 (4) (c) Stated: First time To be completed by: Immediate action required (10 November 2022)	<p>The registered person shall provide adequate means of escape by ensuring combustible items are not inappropriately stored under stairwells.</p> <p>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.</p> <p>Ref: 5.1</p>
Area for improvement 4 Ref: Regulation 30 Stated: First time To be completed by: Immediate action required (10 November 2022)	<p>The registered person shall ensure that appropriate notifications are submitted to RQIA without delay. This relates specifically to unwitnessed falls within the home.</p> <p>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.</p> <p>Ref: 5.1</p>

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 Ref: Standard 38 Stated: First time To be completed by: Immediate action required (10 November 2022)	The registered person shall ensure that records regarding staff registration with the NISCC are at all times available for inspection in the home by any person authorised by the RQIA.
	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 21 Stated: First time To be completed by: Immediate action required (10 November 2022)	The registered person shall ensure that accidents, incidents are reported to relevant bodies, specifically the residents' General Practitioner (GP) in accordance with legislation and procedures in relation to unwitnessed falls and a record is maintained.
	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



The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
 [@RQIANews](https://twitter.com/RQIANews)

Assurance, Challenge and Improvement in Health and Social Care