Inspection Report

18 May 2023

Arlington

Type of service: Nursing Home
Address: 7-9 North Parade, Belfast, BT7 2GF
Telephone number: 028 9049 1136

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

1.0 Service information

Organisation: Arlington **Responsible Individual:** Mr Brian Macklin & Mrs Mary Macklin	**Registered Manager:** Mrs Shauneen Marie Carlin **Date Manager Registered**: 11 November 2022
Person in charge at the time of inspection: Mrs Shauneen Marie Carlin	**Number of registered places:** 25
Categories of care: Nursing Home (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:** 24
Brief description of the accommodation/how the service operates: Arlington is a registered nursing home which provides nursing care for up to 25 patients. The home is over three floors with patients' bedrooms located on all three floors. There is a courtyard in front of the home where patients can enjoy time outside. Communal lounges and the dining room are located on the ground floor.	

2.0 Inspection summary

An unannounced inspection took place on 18 May 2023, from 10.45am to 2.45pm. 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 for follow up at the next care inspection.

Review of medicines management found that medicines were stored safely and securely. Medicine records and medicine related care plans were largely maintained to a satisfactory standard. 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 in relation to the administration of medicines via the enteral route was identified. Details of the area for improvement have been included in the quality improvement plan.

Despite one area for improvement being identified, it was concluded that overall, the patients were being administered their medicines as prescribed. 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 to staff and management about how they plan, deliver and monitor the management of medicines.

4.0 What people told us about the service

The inspector met briefly with two residents during the inspection. Both spoke positively about the care received in Arlington and how their medicines were managed. Residents were observed to be relaxing in the communal lounge of the home.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

The inspector also met with the care staff, the deputy manager, the manager and the regional manager.

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 21 September 2022		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 41 **Stated:** First time	The registered person shall ensure that the staff duty rota is maintained in keeping with legislation and best practice guidance. This specifically relates to: • the full name of all staff working in the home should be included • the duty rota does not evidence the use of correction fluid.	**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 4 **Stated:** First time	The registered person shall ensure that repositioning records evidence the delivery of pressure area care as prescribed in 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.

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. 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 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 prescribing and administration which included the recommended consistency level were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route. However, the regimen detailing the prescribed nutritional supplement and recommended fluid intake in place had been hand amended and it was not clear from the records what the current recommendations were.

An obsolete regimen remained in the medicines file; these should be suitably archived to ensure staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient. 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 area was observed to be securely locked to prevent any unauthorised access. However, the storage area was found to be cluttered and untidy. The manager provided an assurance that the storage area would be tidied and de-cluttered to ensure medicines belonging to each patient could be easily located. Staff were also reminded to consistently record the temperature of the medicine storage area to ensure medicines are stored according to the manufacturer's instructions. 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. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. The records were filed once completed and 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 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 will help staff to identify medicine related incidents.

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. Guidance on identifying and reporting incidents was provided during the inspection to ensure that all staff were aware of the types of medication incidents which must be reported to RQIA.

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

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. Competency had been assessed following induction and annually thereafter. Ongoing review was monitored through supervision sessions with staff. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	0	3*

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

The area for improvement and details of the Quality Improvement Plan were discussed with Mrs Shauneen Carlin, Registered Manager and Mrs Christine Thompson, Regional Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for Improvement 1 **Ref:** Standard 41 **Stated:** First time **To be completed by:** With immediate effect (21 September 2022)	The registered person shall ensure that the staff duty rota is maintained in keeping with legislation and best practice guidance. This specifically relates to: • the full name of all staff working in the home should be included • the duty rota does not evidence the use of correction fluid.
	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 4 **Stated:** First time **To be completed by:** With immediate effect (21 September 2022)	The registered person shall ensure that repositioning records evidence the delivery of pressure area care as prescribed in 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 3 **Ref:** Standard 29 **Stated:** First time **To be completed by:** With immediate effect (18 May 2023)	The registered person shall review the management of medicines administered via the enteral route to ensure the latest regimen detailing the prescribed nutritional supplement and recommended fluid intake is accurate and up to date. Obsolete records should be removed from the medicines file and suitably archived. Ref: 5.2.1
	Response by registered person detailing the actions taken: New regime from Dietician, detailing prescribed nutritional supplement and recommended fluid intake has been put in the resident who is prescribed enteral diet Kardex so that it is easily seen and the old one has been removed. There are plans to declutter the treatment room and boxes ordered for removal to storage, a new column will be added onto nightly temperature check to reflect daily temperature in the room. A large fan has also been ordered to keep the room cool in warmer weather so that the integrity of the medications will not be compromised.

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