The Regulation and Quality Improvement Authority

Inspection Report

14 July 2021

Ballymaconnell

Type of service: Nursing Home
Address: 48 Ballymaconnell Road, Bangor, BT20 5PS
Telephone number: 028 9127 1819

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: Ballymaconnell Private Nursing Home Ltd **Responsible Individual:** Mr Colin Mimmon	**Registered Manager:** Ms Fiona McAufield **Date registered:** 10 December 2019
Person in charge at the time of inspection: Ms Fiona McAufield	**Number of registered places:** 26 The home is also approved to provide care on a day basis for two persons.
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:** 14
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide nursing care for 26 patients.	

2.0 Inspection summary

An unannounced inspection took place on 14 July 2021 between 10.30 and 2.50pm. The inspection was carried out by a pharmacist inspector.

This inspection focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care 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.

To complete the inspection 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 was reviewed.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

4.0 What people told us about the service

We met with one nurse, the manager and the regional manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well. Patients were observed to be relaxing in the foyer and lounge.

Nurses expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after patients and meet their needs. They spoke highly of the support given by management.

In order to reduce footfall throughout the home, the inspector did not meet with any patients. 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 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 last inspection?

Areas for improvement from the last inspection on 19 October 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure all prescribed creams kept in the nursing home are stored in a secure place.	**Met**
	Action taken as confirmed during the inspection: The manager advised that risk assessments have been completed. Prescribed emollients were stored securely under each patient's sink.	
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall make suitable arrangements to minimise the risk of infection. This is in relation to the appropriate use of hand sanitising gels, gloves and the storage of open packets of gloves and wipes in the bathroom.	**Met**
	Action taken as confirmed during the inspection: Staff were observed using sanitising gels frequently. Gloves and open packs of wipes were not observed in the bathrooms.	
Area for improvement 3 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered person shall ensure as far as is reasonably practicable all parts of the home which patients have access to are free from hazards to their safety. This is in relation to an electric hairdryer stored in a bathroom.	**Met**
	Action taken as confirmed during the inspection: The freestanding hairdryer had been moved to a storage room. It was not in use.	
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for improvement 1 **Ref**: Standard 40 **Stated:** First time	The registered person shall ensure staff are supervised and their performance appraised according to the policy and procedure in the home to promote the delivery of quality care and services.	**Met**

	Action taken as confirmed during the inspection: The home's policy states that appraisals should be completed annually and supervisions twice each year. Records of completed/ scheduled appraisals and supervisions showed that this frequency had been achieved.	

No areas for improvement were identified at the last medicines management inspection on 9 September 2017.

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 will 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 and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they are written and updated to provide a double check that they were accurate.

Obsolete personal medication records, warfarin dosage directions (received via email and printed) and insulin regimens had not been cancelled and archived. This is necessary to ensure that nurses can only refer to the up to date directions and to ensure that correct information is provided to another healthcare professional. An area for improvement was identified.

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, self-administration of medicines 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 nurses 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 for two patients. Nurses knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Care plans for both patients were in place, however, for one patient the care plan did not detail which medicine was prescribed and for the second patient the dosage directions were unclear. Directions for use were clearly recorded on the personal medication records. For one patient the medicine was prescribed to be administered "once daily, when required" but it had been administered more than once on a number of days. The reason for and outcome of administration were not routinely recorded and the daily progress notes did not indicate that the patients had been distressed. The manager agreed to clarify the dosage directions with the GP following the inspection. RQIA received this information via email following the inspection. The management of distressed reactions should be reviewed and revised to ensure that:

- up to date care plans are in place
- the name of the prescribed medicine and dosage directions are clearly recorded in the care plan
- the reason for and outcome of each administration is recorded
- regular use is referred to the prescriber for review

An area for improvement was identified.

The management of pain was reviewed. Nurses advised that they were familiar with how each patient expressed their pain. Care plans were in place and there was evidence that pain relief was administered as prescribed.

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 patients.

The management of thickening agents and nutritional supplements was reviewed for three patients. Speech and language assessment reports and up to date care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

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 the majority of medicines were available for administration when patients required them. Nurses advised that they had a good relationship with the

community pharmacist and that medicines were supplied in a timely manner. However, eye drops were out of stock for two patients; for one patient several doses had been omitted. This was discussed in detail with management. Systems should be reviewed to ensure that medicines do not run out of stock. The manager should be made aware of any potential out of stocks. An area for improvement was identified. The manager submitted incident report forms to RQIA following the inspection detailing the action which had already been taken and would be undertaken to prevent a recurrence.

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. Nurses were reminded that lidocaine patches should be dated when opened and that the packaging must be re-sealed. In addition inhaler spacer devices should be cleaned /replaced regularly; the nurse agreed to order replacements during the inspection.

The disposal arrangements for medicines were satisfactory.

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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. On a small number of occasions nurses were recording that the medicine had been omitted without recording the reason for the omission, for example, refusal, out of stock. The manager agreed to discuss this finding with nurses and to monitor as part of her audit.

The audits completed at the inspection indicated that the majority of medicines had been administered as prescribed. However, audit discrepancies were observed in the administration of four liquid medicines. The manager was requested to investigate these discrepancies to report the findings to the patient and appropriate authorities, including RQIA.

The findings of the inspection indicate that the audit process should be further developed to include all aspects of the management of medicines. The audits should cover care plans, the management of distressed reactions, stock control, record keeping, the administration of liquid medicines and the management of medicines on admission. 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 are recorded in a controlled drug record book. The records reviewed had been maintained to the required standard.

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.

The admission process for patients new to the home or returning to the home after receiving hospital care was reviewed. Nurses advised that robust arrangements were in place to ensure that they were provided with an accurate list of medicines from the hospital and this was shared with the patient's GP and the community pharmacist. For one recent admission, two anomalies on the patient's hospital discharge letter had not been clarified with the hospital. The manager confirmed via email that this was followed up with the hospital pharmacist following the inspection; the patient had been administered the correct doses of the medicines. Nurses must follow up any discrepancies in hospital discharge letters without delay to ensure that medicines are administered in accordance with the most recent directions. An area for improvement was identified.

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.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. 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. The findings of this inspection indicate that the auditing system is not robust and hence incidents may not be identified. A robust audit system which covers all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff. See Section 5.2.3.

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 are supported to do so. Policies and procedures should be up to date and readily available for staff use.

Nurses in the home had received a structured induction which included medicines management. Competency had been assessed following induction and annually thereafter. A written record was completed for induction, training and competency assessments.

The manager advised that the findings of the inspection would be discussed with nurses for ongoing improvement.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

Whilst areas for improvement were identified in relation to the management of distressed reactions, stock control, record keeping, the management of medicines on admission and the audit system, RQIA is assured that, with the exception of a small number of medicines, the patients were administered their medicines as prescribed.

We would like to thank the patients and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	4	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Fiona McAufield, Registered Manager, and Ms Angela Dorrian, Regional 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 the inspection	The registered person shall review and revise the recording systems in place for the management of distressed reactions as detailed in the report. Ref: 5.2.1
	Response by registered person detailing the actions taken: All nurses have been informed of the need for a separate care plan covering each medication for distressed reactions. Nurses are also aware of the requirement to make notes in the daily recordings re effects (desired/unwanted) of such medications.
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that medicines are available for administration as prescribed. Ref: 5.2.2
	Response by registered person detailing the actions taken: Nurses have been asked to ensure the monthly order is carefully completed to ensure no medications run short and therefore are available when required.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall implement a robust audit tool which covers all aspects of the management of medicines. Action plans to address shortfalls should be implemented. Ref: 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: A thorough audit was completed following the inspection and any discepancies amended. This was all actioned by 6.8.21.
Area for improvement 4 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that any discrepancies in the hospital discharge information are followed up without delay to ensure that medicines are administered in accordance with the correct directions. Ref 5.2.4
	Response by registered person detailing the actions taken: Nurses now know the importance of double-checking hospital discharge letters and questioning any issues immediately with hospital staff or GP.

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person should ensure that obsolete personal medication records, warfarin dosage directions and insulin regimens are cancelled and archived. Ref: 5.2.1
To be completed by: From the date of the inspection	**Response by registered person detailing the actions taken:** Obsolete personal medications records, warfarin dosage directions and insulin regimes are now cancelled and archived.

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

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