Inspection Report
17 August 2020

Oakmont Lodge Care Home Nursing Unit

Type of Service: Nursing Home
Address: 267 - 271 Old Belfast Road, Bangor, BT19 1LU
Tel No: 028 9146 5822
Inspector: Helen Daly

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home which is registered to provide care for up to 29 patients.

2.0 Service details

Organisation/Registered Provider: Dunluce Healthcare Bangor Ltd **Responsible Individual:** Mr Ryan Smyth	**Registered Manager and date registered:** Mrs Juliet Green 25 June 2018
Person in charge at the time of inspection: Mrs Juliet Green	**Number of registered places:** 29
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	**Total number of patients in the nursing home on the day of this inspection:** 28

3.0 Inspection focus

This unannounced inspection took place on 17 August 2020 from 10.10 to 15.20.

The inspection focused on medicines management within the home.

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the last inspection findings, registration information, and any other written or verbal information received.

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

The following records were examined and/or discussed during the inspection:

- the care records for three patients requiring a modified diet
- the care records for three patients prescribed medication for administration on a “when required” basis for the treatment of distressed reactions
- personal medication records, medicine administration records, medicine receipt and disposal records
- controlled drug record book
- governance and auditing arrangements
- staff medicines management training and competency assessments
- management of medication incidents
- RQIA registration certificate

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Juliet Green, Registered Manager, as part of the inspection process and can be found in the main body of the report.

5.0 What has this service done to meet any areas for improvement made at or since the last medicines management and care inspections?

No areas for improvement were identified at the last care inspection on 4 November 2019.

Areas for improvement from the last medicines management inspection on 23 February 2018		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Nursing Home Regulations 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that records for the administration of thickening agents are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of thickening agents for three patients. Care plans and up to date speech and language assessments were in place. Thickening agents were recorded on the personal medication records and medication administration records. Care assistants recorded administration on separate recording sheets. Registered nurses had been reminded to review these recording sheets daily to ensure that they are accurately maintained.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that the management of medicines on admission/re-admission to the home is reviewed and revised.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of medicines on admission/re-admission to the home for two patients. Satisfactory systems were in place. Records of the quantity of each medicine received had been maintained.	

6.0 What people told us about this service

On the day of inspection we spoke to three patients. They said that they enjoyed living in the home. They were on their way to enjoy an afternoon of music; a musician was playing outside the home. One of these patients had just returned from a visit with family.

Good interactions were observed between staff and patients. Staff were warm and friendly and knew the patients well.

We spoke with three registered nurses and three care assistants. They 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. Comments made included:

"This place is top notch. The patients are really well cared for. I wish I lived here. I tell everyone that this is a good care home."

"I love it here. It's a great place for patients and staff. I get really good training."

Feedback methods also included a staff poster and paper questionnaires which were given to the registered manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. No questionnaires were returned to RQIA within the timeframe for inclusion in this report.

7.0 Medicines Management

7.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in care homes should be registered with a general medical 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 may be done by the GP or the pharmacist.

Patients in the home were registered with local GPs and medicines were reviewed and dispensed by the community pharmacist.

Personal medication records were in place for each patient. These contained a list of all 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 e.g. medication reviews, transfers to hospital.

The majority of records examined had been fully and accurately completed. One discrepancy was highlighted to staff; the prescription was checked and the personal medication record was updated during the inspection. The medication had been administered as prescribed. In line with best practice, a second registered nurse had checked and signed these records when they were written and updated to provide a double check that they were accurate.

Copies of patients' prescriptions were retained in the home so that any entry on the personal medication record could be checked against the prescription. This again contributes to confidence that the systems in place are safe.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for three patients. These medicines were used infrequently. The reason for and outcome of the administration were recorded in the daily care records. Directions for use were clearly recorded on the personal medication records. However, a care plan was not in place for one patient. The deputy manager advised that this would be written following the inspection. Due to this assurance an area for improvement was not identified.

We reviewed the management of epilepsy. Dosage directions for the use of emergency medication were clearly recorded on the personal medication record and the registered nurses were knowledgable regarding the care required. However, the epilepsy management plan was not up to date. The registered manager advised that the prescriber was contacted and an up to date plan which reflected the current prescription was requested on 18 August 2020.

Satisfactory systems were in place for the management of thickening agents, pain and warfarin.

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

Medicines must be available to ensure that they are administered to patients as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

The records inspected showed that medicines were available for administration when patients required them. The registered manager advised that staff had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

On arrival at the home the treatment room was observed to be securely locked. It was tidy and organised so that medicines belonging to each patient could be easily located. The medicines currently in use were stored within medicine trolleys that were also securely stored so that there could be no unauthorised access. Controlled drugs were stored in a controlled drug cabinet.

Medicines which needed to be stored at a colder temperature were stored in the medicines refrigerator. The maximum and minimum temperatures were monitored and recorded daily and were within the required range.

Medicines disposal was discussed with the registered manager and registered nurses. Medicines including controlled drugs were safely disposed of. Disposal of medicine records were examined. They had been completed so that medicines could be accounted for.

7.3 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 was completed on pre-printed medicine administration records (MARs) when medicines were administered to patients. A sample of these records were reviewed and they had been fully and accurately completed. One discrepancy was highlighted to the registered nurses who provided assurances that the medicine had been administered as prescribed. The audit completed at the inspection indicated that the medicine had been administered as prescribed.

Daily running stock balances were maintained for the majority of medicines. The management team also completed monthly audits. The stock balances and audits showed that medicines had been given as prescribed.

The date of opening was recorded on the majority of medicines so that they can be easily audited. This is good practice. The majority of audits we completed at inspection indicated that medicines were being administered as prescribed. However, some minor discrepancies in the administration of a small number of liquid medicines were observed. It was agreed that the administration of liquid medicines would be closely monitored.

7.4 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.

We reviewed the admission process for patients. Written confirmation of their prescribed medicines had been obtained. The personal medication records had been accurately updated by two registered nurses. Medicines had been received into the home and administered in accordance with the most recent prescription.

7.5 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 that 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.

The audit system in place helps registered nurses/management to identify medicine related incidents. The management team were familiar with the type of incidents that should be reported.

We discussed the management of medication related incidents. There was evidence that the incidents had been investigated and learning had been shared with registered nurses. The incidents had been reported to the prescribers for guidance and to the appropriate authorities including RQIA.

7.6 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, registered nurses who administer medicines to patients must be appropriately trained. The registered manager has a responsibility to check that registered nurses are competent in managing medicines and that they are supported to do this.

Registered nurses in the home had received a structured induction which included medicines management. Records of this activity were maintained and showed that medicines related training and competency assessment were completed annually.

Care assistants who were responsible for the administration of thickening agents and topical preparations e.g. creams and emoillents, received training on these delegated tasks during their induction. The deputy manager advised that registered nurses had been requested to review the management of thickening agents and topical preparations on a daily basis.

8.0 Evaluation of Inspection

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

The outcome of this inspection concluded that all areas for improvement identified at the last medicines management inspection had been addressed. No new areas for improvement were identified.

Whilst we highlighted some issues, it was ackncowledged that these had already been identified through the recent management audits and discussed with the registered nurses for improvement. Management advised that they would continue to audit the management of medicines to ensure sustained improvements. This will ensure that patients and their relatives can be assured that medicines are well managed within the home.

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

9.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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