The Regulation and Quality Improvement Authority

Inspection Report

5 December 2023

Oakmont Lodge Care Home Nursing Unit

Type of service: Nursing Home
Address: 267 – 271 Old Belfast Road, Bangor, BT19 1LU
Telephone number: 028 9146 5822

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: Dunluce Healthcare Bangor Ltd **Responsible Individual:** Mr Ryan Smith	**Registered Manager:** Mrs Emma Kerrigan, registration pending
Person in charge at the time of inspection: Mrs Emma Kerrigan	**Number of registered places:** 41
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia PH(E) - physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 41
Brief description of the accommodation/how the service operates: Oakmont Lodge Care Home Nursing Unit is a registered nursing home which provides nursing care for up to 41 patients. The home is divided in two units; the McKee unit located on the first floor in which patients receive general nursing care; and a 12 bedded unit which provides care to people living with dementia. There is also a registered residential care home located within the same building.	

2.0 Inspection summary

An unannounced inspection took place on 5 December 2023, from 10.30am to 3.00pm. This was completed by a pharmacist inspector. The inspection 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 medicine records were well maintained. 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 was identified in relation to ensuring there is a written confirmation of medicines obtained at or prior to admission for new patients.

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 and management 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 the manager. 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 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 care inspection on 14 November 2023		
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) **Stated:** First time	The registered person shall ensure that nursing staff manage falls in keeping with best practice. All actions taken post fall should be 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 16 (2) (b) **Stated:** First time	The registered person shall ensure that the patient's plan is kept under review and reflective of their assessed needs. This area for improvement is made with specific reference to nutrition and choking risk.	**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 18 (2) (c) (e) **Stated:** First time	The registered person shall ensure clean bedding is used at all times suitable to the needs of patients. Arrangements must be in place for the regular laundering of bed linen.	**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 the Care Standards for Nursing Homes (December 2022)		Validation of compliance
Area for Improvement 1 **Ref:** Standard 37.4 **Stated:** First time	The registered person shall ensure that patients' fluid intake over a 24-hour period is reviewed by a registered nurse where appropriate and accurate records are 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.	
Area for improvement 2 **Ref:** Standard 11 **Stated:** First time	The registered person shall ensure activities are planned and delivered to provide structure to the patient's day. These should be developed in consultation with the patients and reviewed at least twice yearly to ensure it meets patients changing needs. The programme of activities should be displayed in a suitable format so that patients know what is scheduled. Individual activity assessments should be completed and reviewed as required to inform and compliment patient centred care plans. A contemporaneous record of activities delivered must be retained.	**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. One discrepancy was highlighted to nurses for remedial action. 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 for two patients. 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.

On the day of the inspection care plans for two patients who require insulin to manage their diabetes had been archived in error. This was identified by nurses and highlighted to the manager who ensured they were retrieved from archiving and available for use. This was actioned during the inspection.

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 for the management of warfarin.

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 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 reviewed were found to have been fully and accurately completed. The records were filed once completed and were 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 not supplied in a monitored dosage system 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 not in place to manage medicines for new patients or patients returning from hospital. Written confirmation of one patient's medicine regime was not obtained at or prior to admission. This is necessary to ensure that medicines are administered in accordance with the prescriber's 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. 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 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 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

One new area for improvement has been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, 2022.

	Regulations	Standards
Total number of Areas for Improvement	3*	3*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Emma Kerrigan, 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 The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** Immediate action required (14 November 2023)	The registered person shall ensure that nursing staff manage falls in keeping with best practice. All actions taken post fall should be appropriately recorded in the patient's care record. **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.** Ref: 5.1
Area for improvement 2 **Ref:** Regulation 16 (2) (b) **Stated:** First time **To be completed by:** Immediate action required (14 November 2023)	The registered person shall ensure that the patient's plan is kept under review and reflective of their assessed needs. This area for improvement is made with specific reference to nutrition and choking risk. **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.** Ref: 5.1
Area for improvement 3 **Ref:** Regulation 18 (2) (c) (e) **Stated:** First time **To be completed by:** Immediate action required (14 November 2023)	The registered person shall ensure clean bedding is used at all times suitable to the needs of patients. Arrangements must be in place for the regular laundering of bed linen. **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.** Ref: 5.1
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 37.4 **Stated:** First time **To be completed by:** Immediate action required (14 November 2023)	The registered person shall ensure that patients' fluid intake over a 24-hour period is reviewed by a registered nurse where appropriate and accurate records are 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

Area for improvement 2 **Ref:** Standard 11 **Stated:** First time **To be completed by:** Immediate action required (14 November 2023)	The registered person shall ensure activities are planned and delivered to provide structure to the patient's day. These should be developed in consultation with the patients and reviewed at least twice yearly to ensure it meets patients changing needs. The programme of activities should be displayed in a suitable format so that patients know what is scheduled. Individual activity assessments should be completed and reviewed as required to inform and compliment patient centred care plans. A contemporaneous record of activities delivered must be retained.
	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 28 **Stated:** First time **To be completed by:** Immediate action required (5 December 2023)	The registered person shall ensure that written confirmation of medicines is obtained from the prescriber at or prior to admission for new patients. Ref: 5.2.4
	Response by registered person detailing the actions taken: All nurses informed in relation to the policy, that wriiten confirmation of medicines is required from the prescriber at or prior to admission for new patients.

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