The Regulation and Quality Improvement Authority

Inspection Report

12 & 14 December 2023

Nicholson House

Type of service: Nursing Home
Address: 8 Antrim Road, Lisburn, BT28 3DH
Telephone number: 028 9267 4126

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: Nicholson House Lisburn Ltd **Responsible Individual:** Leon Desmond Loughran	**Registered Manager:** Ms Amanda McAloon **Date registered:** 22 August 2023
Person in charge at the time of inspection: Ms Amanda McAloon	**Number of registered places:** 33
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:** 33
Brief description of the accommodation/how the service operates: Nicholson House is a registered nursing home which provides nursing care for up to 33 patients. Patients' bedrooms, lounges and dining rooms are located over both floors of the home. Patients have access to an enclosed outside patio area.	

2.0 Inspection summary

An unannounced inspection took place on 12 December 2023 from 10.15am to 3.15pm and on 14 December 2023 from 10.45am to 1.30pm. The inspection was completed by a pharmacist and a finance inspector and focused on medicines management and patients' finances 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 and the management of patients' finances.

Review of medicines management found that medicine records and medicine related care plans were generally well maintained. Staff were trained and competent to manage medicines and patients were administered the majority of their medicines as prescribed.

One area for improvement identified at the last care inspection has been carried forward and will be followed up at the next care inspection and one has been assessed as met.

One area for improvement identified at the last inspection has been stated for a second time and one new area for improvement has been identified in relation to monitoring the temperature of medicine storage areas.

Whilst areas for improvement were identified, it was concluded that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed.

With regards to finance, no new areas for improvement were identified at the inspection on 14 December 2023. One area identified within Section 5.2.7 of this report will be reviewed at the next RQIA inspection.

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.

In relation to finance, a sample of patients' financial records were reviewed which included; records of transactions, patients' written agreements, bank statements, records of patients' financial arrangements and patients' personal property. Controls surrounding the management of patients' monies and property were also reviewed.

4.0 What people told us about the service

The inspectors met with nursing staff, the deputy manager and the 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.

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 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?

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 28 July 2023</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</td><td>Validation of compliance</td></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Regulation 13 (4) (a)

Stated: First time</td><td>The registered person shall make suitable arrangements for the secure storage of oxygen cylinders.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Oxygen cylinders were stored safely and securely in a locked medicines storage room.</td></tr>
<tr><td rowspan="2">Area for Improvement 2

Ref: Regulation 13 (4) (a)

Stated: First time</td><td>The registered person shall ensure that any medication which is kept in the nursing home is stored in a secure place in order to make proper provision for the nursing, health and welfare of patients.</td><td rowspan="2">Partially met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The majority of medicines were stored securely. However, two medicine refrigerators at the nursing station were unlocked and accessible to anyone.

This area for improvement has been restated</td></tr>
<tr><td colspan="2">Action required to ensure compliance with Care Standards for Nursing Homes, December 2022</td><td>Validation of compliance</td></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Standard 21

Stated: First time</td><td>The registered person shall ensure that where required, choking risk assessments are completed. Care plans will be reviewed in line with the outcomes of a choking risk assessments.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>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.</td></tr>
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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 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. The reason for and outcome of each administration were recorded in the daily notes.

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. Staff provided an assurance that they would update one administration record to include the recommended consistency level.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside the recommended range. Staff were reminded that the date of opening should be recorded for all in use insulin pen devices to facilitate disposal at expiry.

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 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. The temperature of the medicine storage areas was not monitored or recorded to ensure that medicines were stored appropriately. The temperature of the medicines storage area should be monitored and recorded daily. Corrective action should be taken if temperatures outside the required range are observed. An area for improvement was identified.

Two medicine refrigerators accessible to staff and patients were found to be unlocked. An area for improvement was stated for the second time.

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.

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. 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 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, a small number of minor discrepancies were highlighted to the manager for close monitoring. In recent months management had been completing more focused monthly medicines audits but plan to return to a wider audit following the inspection.

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.

5.2.7 Finance Inspection

A safe place was provided within the home for the retention of patients' monies and valuables. There were satisfactory controls around the physical location of the safe place and the members of staff with access to it. A review of a sample of records of monies held on behalf of some patients showed that the records were up to date during the inspection on 14 December 2023. No valuables were held on behalf of patients at the time of the inspection.

Comfort fund monies were held on behalf of patients. These are monies donated to the home for the benefit of all patients. A review of a sample of transactions from the comfort fund confirmed that purchases from the fund were for the benefit of all patients. Receipts from the purchases were available for inspection.

Discussion with the manager confirmed that no bank accounts were used to retain patients' monies. A bank account was in place to retain the comfort fund monies. A sample of records evidenced good practice as reconciliations (checks) of monies held on behalf of patients were undertaken weekly. The comfort fund monies held in the bank account were reconciled on a monthly basis. The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

Discussion with the manager confirmed that no member of staff was an appointee for any patient, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

Three patients' finance files were reviewed; written agreements were retained within all three files. The agreements showed the current weekly fee paid by, or on behalf of, the patients. A list of services provided to patients as part of their weekly fee was also included in the agreements. The agreements reviewed were signed by the patient, or their representative, and a representative from the home.

Review of records confirmed that a weekly third party contribution (top up) was paid on behalf of newly admitted care managed patients. Discussion with the manager confirmed that the third party contribution was not for any additional services provided to patients but the difference between the tariff for the home and the regional rate paid by the health and social care Trusts. The patients' written agreements reviewed at the inspection on 14 December 2023 were up to date to reflect the top up paid on behalf of the patients.

A review of a sample of fees received from two patients (including third party payments) evidenced that the records were up to date at the time of the inspection. Discussion with the manager confirmed that no patient was paying an additional amount towards their fee over and above the amount agreed with the health and social care Trusts.

A review of a sample of payments to the hairdresser and podiatrist showed that the records were up to date. Two signatures were recorded against each entry in the patients' records and receipts from the transactions were retained for inspection.

A review of a sample of monies deposited at the home on behalf of one patient evidenced that the records were up to date at the time of the inspection. Receipts were provided to the person depositing the monies who had signed the records along with a member of staff.

A sample of one patient's file evidenced that a property record was in place for the patient. The record was updated with additional items brought into the patient's room following admission. There was no recorded evidence to show that the personal possessions were checked, at least quarterly, and signed by two members of staff. The manager provided assurances that a system for recording the reconciliation of patients' personal possessions would be implemented following the inspection. This will be reviewed at the next RQIA inspection.

Policies and procedures for the management and control of patients' finances and property were available for inspection. The policies were readily available for staff use. The policies were reviewed at least every three years.

Discussion with staff confirmed that no transport scheme was in place at the time of the inspection on 14 December 2023.

No new finance related areas for improvement were identified during the inspection on 14 December 2023.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	1*	2*

* The total number of areas for improvement includes one that has been stated for a second time and one which is carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Amanda McAloon, Registered 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 Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (4) (a) **Stated:** Second time **To be completed:** Immediate action required (12 December 2023)	The registered person shall ensure that any medication which is kept in the nursing home is stored in a secure place in order to make proper provision for the nursing, health and welfare of patients. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Medicines stored in the homes two refirgerators have now been secured. All nursing staff have been made aware they must be secured at all times.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 21 **Stated:** First time **To be completed by:** Immediate action required (28 July 2023)	The registered person shall ensure that where required, choking risk assessments are completed. Care plans will be reviewed in line with the outcomes of a choking risk assessments.
	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 30 **Stated:** First time **To be completed by:** Immediate action required (12 December 2023)	The registered person shall ensure that the temperature of the medicines storage areas is monitored and recorded daily. Corrective action should be taken if temperatures outside the required range are observed. Ref: 5.2.2
	Response by registered person detailing the actions taken: The temperature of the medication storage areas are now being monitored and recorded daily.

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

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

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