Unannounced Medicines Management Inspection Report
14 February 2019

Wood Green Nursing Home

Type of Service: Nursing Home
Address: Wood Green, Circular Road, Jordanstown, BT37 0RJ
Tel No: 028 9036 9901
Inspector: Judith Taylor

It should be noted that 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 the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with that provides care for up to 32 patients with healthcare needs as detailed in Section 3.0. This home shares the same building as Wood Green Residential Home.

3.0 Service details

Organisation/Registered Provider: Wood Green Management Company (NI) Limited **Responsible Individual:** Mrs Yvonne Diamond	**Registered Manager:** Ms Debby Ann Gibson
Person in charge at the time of inspection: Ms Debby Gibson	**Date manager registered:** 21 September 2018
Categories of care: Nursing Homes (NH): DE – Dementia I – Old age not falling within any other category	**Number of registered places:** 32 comprising: NH-DE - maximum of 19 patients NH-I - maximum of 13 patients

4.0 Inspection summary

An unannounced inspection took place on 14 February 2019 from 10.50 to 16.20.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines governance, training and competency assessment, the management of controlled drugs, the administration of medicines, and the safe storage of medicines.

Areas for improvement were identified in relation to the completion of records, medicine labelling and care plans.

The patient and relatives we met with spoke positively about the staff and the care provided. There was a warm and welcoming atmosphere in the home and the patients were observed to be relaxed and comfortable in their environment.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	4

Details of the Quality Improvement Plan (QIP) were discussed with Ms Debby Gibson, Registered Manager and Mrs Yvonne Diamond, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection. Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 8 January 2019. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- recent inspection reports and QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection.

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with one patient, two relatives, two care assistants, two registered nurses, the registered manager and the responsible individual.

We provided 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA and we asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record books
- medicine audits
- care plans
- training records
- medicines storage temperatures
- policies and procedures

We left ‘Have we missed you?’ cards in the home to inform patients and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 8 January 2019

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 6 October 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that the refrigerator temperature is monitored and recorded daily to ensure that it remains within the required range of 2^{o}C and 8^{o}C.	**Met**
	Action taken as confirmed during the inspection: Medicines refrigerator temperatures were recorded each day; they were maintained within the accepted range of 2^{o}C to 8^{o}C.	
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that a complete record of all medicines received into the home is maintained.	**Met**
	Action taken as confirmed during the inspection: With the exception of one patient's medicines, records of incoming medicines were well maintained. This was discussed with management and staff who advised this is the expected practice and had been an oversight and would be urgently reiterated to staff. Given this assurance, this area for improvement has been assessed as met.	

Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that medicine management audits are completed regularly.	**Met**
	Action taken as confirmed during the inspection: There was evidence of daily, weekly and monthly audits being completed on a variety of medicines and medicine records.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. Staff competency assessments were completed following induction, at least annually and more frequently as required. The impact of training was monitored through team meetings, supervision and annual appraisal. A programme of medicines related training was in place. Planned training this month included the management of dysphagia, dementia, distressed reactions and diabetes.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

We examined the arrangements in place for the management of new patient's medicines and changes in medicines. We found there were largely satisfactory procedures in place and written confirmation of medicine regimes and any medicine changes were usually obtained. Personal medication records were printed and updated by two trained staff, which is safe practice. However, in relation to the admission of one patient, we could not locate the medicine regime or record of receipt of medicines and the handwritten medication administration records (MARs) were not signed by two trained staff. This was discussed with management for review and area for improvement was identified. See also Section 6.5.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify, report and follow up any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

The management of controlled drugs was reviewed. Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

There were arrangements in place to ensure that discontinued or expired medicines were uplifted by a clinical waste company. In relation to the disposal records, see Section 6.5.

We examined the records regarding high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. Care plans were maintained; however, one care plan required updating in relation to the insulin dose prescribed. An area for improvement regarding care planning was made in Section 6.5.

The management of medicines which were required to be crushed and administered in disguised form was examined. Management and staff advised that this had been agreed with the multidisciplinary team; however, authorisation was not recorded in the patient's notes or care plan. See also Section 6.5.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. In relation to medicines with a limited shelf life once opened, satisfactory arrangements were in place for eye preparations; however, we noted two of the five insulin pen devices in current use were not labelled and four did not state the date of opening. An area for improvement was identified. Oxygen equipment was checked at regular intervals. See Section 6.2 regarding the cold storage of medicines.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the management of controlled drugs.

Areas for improvement

The management of new patient's medicines should be reviewed.

The necessary arrangements should be made to ensure that all insulin pens are labelled and are marked with the date of opening.

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Most of the audit outcomes on a variety of medicines indicated that medicines were being administered in accordance with the prescribers' instructions. However, we could not complete the audits on one patient's medicines; see Section 6.4.

There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly or three monthly medicines were due. The benefit of also stating the next date of three monthly injections on MARs/or a separate administration record was discussed.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the patient's health were reported to the prescriber. This was evidenced in the care notes regarding one patient.

We reviewed a variety of medicine records. Whilst the majority were well maintained and facilitated the audit process, some improvements were necessary. A number of recently printed

personal medication records did not contain the patient's drug allergy status or the patient's photograph. Management advised that this information was recorded within the electronic record system and this was a technical issue, which would be resolved with immediate effect. Given these assurances, an area for improvement was not made.

In relation to MARs, we observed a few missing signatures; the audits indicated that all but one of these medicines had been administered but not signed for; and for one medicine, four doses had been missed. It was agreed that this would be closely monitored within the audit process, and raised with the prescriber as necessary. In the instances where information was transcribed onto MARs, two staff should be involved in this process with both staff signing the records. This was also raised in relation to the disposal of medicines. See also Section 6.4. An area for improvement was identified.

The management of pain and distressed reactions was reviewed. Medicine details were recorded on the personal medication records. Care plans were maintained. Staff were aware that distressed reactions may be the result of pain and that ongoing monitoring was necessary to ensure that the patient was comfortable.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Speech and language assessment reports were in place. Records of administration were completed by registered nurses and care staff. Care plans were in place, however, some required updating. An area for improvement regarding care planning was made. See also Section 6.4.

Following discussion with management and staff, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs. Management also advised of the recently implemented medication reviews by the general practitioners, which were currently taking place in the home; these should be completed within two months.

Areas of good practice

There were some examples of good practice in relation to the standard of record keeping and the administration of medicines.

Areas for improvement

Two staff should be involved in the disposal of medicines and transcribing of medicines information; both staff signatures/initials should be recorded.

Care plans should reflect the patient's healthcare needs and be kept up to date at all times.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to patients was not observed during the inspection. Following discussion with staff it was evident they were knowledgeable about the patients' medicines and how the patients preferred to take their medicines.

We noted the warm and welcoming atmosphere in the home. As part of the St Valentine's Day theme, patients were observed to be enjoying the heart shape decorated buns/biscuits provided.

Throughout the inspection, it was found that there were good relationships between the staff, the patients and the patients' representatives. Staff were noted to be friendly and courteous. It was clear from observation of staff, that they were familiar with the patients' likes and dislikes.

We met with one patient and two relatives who spoke positively about the care provided, the food and the staff. They stated that staff responded to any requests they had and advised they had no concerns. Comments included:

- "You couldn't get any nicer."
- "Staff are very very good, and friendly."
- "I am happy here and I don't have any pain."
- "We are very pleased with how well xxx (patient) is doing since xxx came here."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Of the questionnaires which were left for patients/patients' representatives, none were returned within the specified time frame (two weeks). Any comments in questionnaires received after the return date will be shared with the registered manager as necessary.

Areas of good practice

Staff listened to patients and relatives and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. We were advised that there were arrangements in place to implement the collection of equality data.

The governance arrangements for medicines management were examined. There was evidence of the auditing and monitoring systems in place; they included daily, weekly and monthly audits and support from the community pharmacist. Management advised of how areas for improvement were shared with staff to address and detailed the new auditing systems which were currently being implemented.

Written policies and procedures for the management of medicines were in place. These had been updated in May 2018. Staff advised that there were procedures in place to ensure that they were made aware of any changes.

There were satisfactory arrangements in place for the management of medicine related incidents. Staff knew how to identify and report incidents, including referral to the safeguarding team as necessary. They provided details of the procedures in place to ensure that all staff were made aware of incidents and systems to prevent recurrence.

We were advised that there were effective communication systems to ensure that all staff were kept up to date. Shift handovers included a written sheet of all patients and in relation to medicines management, these included reference to diabetes, swallowing difficulty and infection. In addition, a 24 hour report was shared with the registered manager for her attention and action as required.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with management.

The staff spoke positively about their work and advised there were good working relationships in the home and with other healthcare professionals. They stated they felt well supported in their work, received good induction and training and stated they had no concerns.

No online questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Debby Gibson, Registered Manager and Mrs Yvonne Diamond, Responsible Individual, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 16 March 2019	The registered person shall review the management of new patients' medicines to ensure the relevant records are in place. Ref: 6.4
	Response by registered person detailing the actions taken: Staff have been advised that confirmation of all prescribed medication should be available for each resident prior to administering any medications. This can take the form of a discharge letter from the hospital or emailed confirmation from the GP. This will be monitored through the weekly audits.
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 16 March 2019	The registered person shall review the management of in use insulin pen devices as detailed in the report. Ref: 6.4
	Response by registered person detailing the actions taken: A discussion has taken place with the Pharmacy and going forward all Insulin pens will now be individually labelled. Staff will monitor this during the signing in of medications. The need for dates of opening on all medications was enforced at Face to Face training.
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 16 March 2019	The registered person shall ensure that two staff are involved in the disposal of medicines and transcribing of medicines information on handwritten medication administration records. Ref: 6.5
	Response by registered person detailing the actions taken: Weekly Medication Audits have been introduced and these include checking handwritten entries on medication administration records. All staff responsible for the disposal of medication have been reminded of the need for two members of staff to witness and sign the disposal records. This was underpinned by attendance at Face to Face medication training.

Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 16 March 2019	The registered person shall ensure that patients' care plans reflect their healthcare needs and these are kept up to date. Ref: 6.4 & 6.5
	Response by registered person detailing the actions taken: A review of care plans has evidenced that all care plans are up to date and recommendations from SLT have been incorporated in to them.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews