Unannounced Post-Registration Medicines Management Inspection Report
19 June 2018

Longfield Care Home

Type of Service: Residential Care Home
Address: 2 Longfield Road, Eglinton, Derry BT47 3PY
Tel No: 028 7181 2552
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 provider 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 residential care home with 11 beds that provides care for residents living with dementia. It is situated on the same site as the nursing home, Longfield Care Home.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr. Maureen Claire Royston	**Registered Manager:** Mrs Louise McCloskey
Person in charge at the time of inspection: Mrs Louise McCloskey	**Date manager registered:** 19 April 2018
Categories of care: Residential Care (RC) DE – Dementia	**Number of registered places:** 11

4.0 Inspection summary

An unannounced inspection took place on 19 June 2018 from 10.05 to 14.05.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

The inspection assessed progress with any areas for improvement identified since the pre-registration care and premises inspections 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 training, governance arrangements, medicines administration, medicine records, medicines storage and the management of controlled drugs.

One area for improvement was identified in relation to transcribing medicines information.

Residents said they were happy in the home and spoke positively about the management of their medicines and the care provided by staff. We noted the warm and welcoming atmosphere in the home.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Louise McCloskey, Registered Manager, 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 pre-registration inspections

No further actions were required to be taken following the most recent inspections on 13 December 2017. 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 returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the home registered

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection the inspector met with two residents, two staff and the registered manager.

We also met with two relatives of patients with respect to the nursing home Longfield Care Home; they had asked to speak with us regarding the care of their relatives.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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

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

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 inspections dated 13 December 2017

The most recent inspections of the home were care and premises inspections. There were no areas for improvement made as a result of these inspections.

6.2 Review of areas for improvement from the last medicines management inspection

This was the first medicines management inspection to the home.

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. An induction process was in place for senior care staff and also for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings and supervision. Competency assessments were completed post induction. Review of competency and appraisal was planned to be completed at least annually. A sample of training and competency records was provided. Refresher training in medicines management, warfarin, dementia and dysphagia had been completed.

The management of new resident's medicines and medicines changes was examined. There were largely satisfactory arrangements in place. Written confirmation of medicine regimes and medicine changes was obtained. Whilst the safe practice of ensuring that personal medication records were written and updated by two members of trained staff, this did not routinely occur when writing the information onto medication administration records. An area for improvement was identified.

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 and report any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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.

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.

The management of high risk medicines was reviewed. In relation to warfarin, written confirmation of the medicine regimes was obtained. Some obsolete dosage regimes required filing and this was addressed at the inspection. A separate administration record was in use and included a daily stock balance check. This record showed that two staff were involved in administering each dose to ensure accuracy, this is a good practice; however, the transcribing of the warfarin details was signed by one staff member, instead of two. An area for improvement in relation to transcribing was stated above.

Injections were administered by the community nurses and records of administration including the next date of administration were maintained.

Discontinued or expired medicines including controlled drugs were returned to the community pharmacy for disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. The medicine refrigerator was checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessments, the management of controlled drugs and medicines storage.

Areas for improvement

In the instances where staff record medicine details onto medicine records, two staff should be involved in this process and both staff should initial the entry.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

The sample of medicines examined had been administered in accordance with the prescriber's instructions.

There were arrangements in place to alert staff of when doses of weekly medicines were due. Reminders were marked out on the medication administration records.

The management of pain and distressed reactions was examined. The medicines were prescribed on the personal medication record and protocols for the administration of these

medicines were maintained. Care plans were in place. In relation to distressed reactions, two medicines were prescribed for one resident; a care plan was in place for each medicine and staff were aware of when to administer the medicines; this should be clearly recorded in the care plan. It was agreed that these care plans would be updated to include information of which medicine was to be administered as first line or second line. A record of the reason for and outcome of the administration were usually recorded on a separate administration record or in the resident's daily notes. Staff confirmed that they knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that this change may be associated with pain.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident's health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for transdermal patches and protocols for 'when required' medicines such as analgesics and sedatives.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for most medicines, which is good practice.

Following discussion with the registered manager and staff and a review of a sample of care files, it was evident that when applicable, other healthcare professionals were contacted in response to the residents' needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 residents was not observed at the time of this inspection. Following discussion with the staff, they advised that residents were given time to take their medicines and medicines were administered as discreetly as possible; they were knowledgeable about the residents' medicines.

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

We met with two residents, who expressed their satisfaction with the staff and the care provided. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were adhered to. They stated they had no concerns. Comments included:

"The staff are very good."
"I like my room, the staff get what I need."
"I really enjoy the activities, I like the chair exercises."
"The food is very good, I had a beautiful lunch."

During the course of the inspection, two relatives who had been visiting the nursing home, situated on the same site, asked to speak with us. Both relatives wanted to tell us about the care provided to their relatives whilst in the nursing home. They spoke very positively about the care and were complimentary regarding all grades of staff.

Of the questionnaires which were left in the home to facilitate feedback from residents and their representatives, four were returned. The responses indicated that they were very satisfied/ satisfied with the care provided in the home. Three comments were made:

"I cannot praise the staff enough for the care and time they give my xxx(relative). They keep me up to date with any issues or problems."

"Everyone is brilliant and looked after my xxx(relative) in a very good manner. The teams were friendly and could not do enough for my xxx(relative) and the family circle will always be grateful and thankful."

"The environment and activities are stimulating, have seen a real rally from my xxx(relative). Early days but we feel we've made the right choice for xxx(relative)."

Any further comments in questionnaires received after the return date will be shared with the registered manager as necessary.

Areas of good practice

There was evidence that staff listened to residents 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

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. We were advised that there were arrangements in place to implement the collection of equality data within Longfield Care Home.

Written policies and procedures for the management of medicines were in place. There was evidence that these were read by staff. Staff confirmed there were systems in place to keep them up to date with any changes.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by staff, management and the community pharmacist, and how areas for improvement were detailed in an action plan, shared with staff to address and systems to monitor improvement.

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 the registered manager; and any resultant action was discussed at team meetings and/or supervision.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. They stated they felt well supported in their work.

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

Areas of good practice

There were examples of good practice found throughout the inspection 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 quality improvement plan (QIP). Details of the QIP were discussed with Mrs Louise McCloskey, Registered Manager, 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 residential care 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 Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

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 QIP via 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) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 31 **Stated:** First time	The registered person shall ensure that two staff are involved in the transcribing of all medicines information on medicine records; both staff should initial the entry. Ref: 6.4
To be completed by: 19 July 2018	**Response by registered person detailing the actions taken:** Supervisions are being completed by our Team Leader with all Care Assistants in the Unit in relation to administration of medications and documentation of same, in particular transcribing of medications and ensuring two signatures are in place. All medication competencies are now up to date and signed off.

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

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