Unannounced Medicines Management Inspection Report
5 September 2018

Arlington

Type of Service: Nursing Home
Address: 7-9 North Parade, Belfast, BT7 2GF
Tel No: 028 9049 1136
Inspector: Helen Daly

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 25 beds that provides care for patients with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Arlington **Responsible Individuals:** Mrs Mary Macklin Mr Brian Macklin	**Registered Manager:** Mrs Jill Stojanovic
Person in charge at the time of inspection: Mrs Jill Stojanovic (10:10 – 10:45) Mr Clarito Lugo (10:45 – 14:20)	**Date manager registered:** 25 May 2018
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 TI – terminally ill	**Number of registered places:** 25

4.0 Inspection summary

An unannounced inspection took place on 5 September 2018 from 10.10 to 14.20.

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 administration, medicine records, medicine storage and the management of controlled drugs.

No areas for improvement were identified at the inspection.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Clarito Lugo, Nurse in charge, as part of the inspection process and can be found in the main body of the report. Findings of the inspection were also discussed with Ms Jill Stojanovic, Registered Manager, via telephone call, following the 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 17 May 2018. 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 home was reviewed. This included the following:

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

During the inspection the inspector met with three patients, one care assistant, the administrator, one registered nurse, the registered manager and the regional manager.

We provided the registered manager with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We left 'Have we missed you?' cards in the foyer of the home to inform patients/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

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

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 17 May 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This 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 1 September 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 review the management of medicines to ensure there are robust arrangements in place for the cold storage of medicines.	**Met**
	Action taken as confirmed during the inspection: Satisfactory recordings were observed for the refrigerator temperature.	
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered person shall review the procedures for the receipt of medicines to ensure that full and accurate records are maintained.	**Met**
	Action taken as confirmed during the inspection: Satisfactory records of medicines received were observed.	

Area for improvement 3 **Ref**: Standard 29 **Stated:** First time	The registered person shall review the management of recording errors.	**Met**
	Action taken as confirmed during the inspection: This area for improvement referred to amending entries on the personal medication records and the use of correction fluid. Entries on the personal medication records were not amended. Correction fluid was not used.	

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. Training had been provided by the community pharmacist in April 2018. Competency assessments had been completed for all registered nurses. Records were available for inspection. Care assistants had received training and been deemed competent to administer thickening agents and emollient preparations.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. The registered manager was in the process of completing “train the trainer” training so that she would be able to provide regular training for all staff.

There were systems in place to ensure that patients had a continuous supply of their prescribed medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

There were procedures in place to ensure the safe management of medicines during a patient’s admission to the home and to manage medication changes. The majority of entries on the personal medication records and hand-written entries on the medication administration records were verified and signed by two registered nurses. This safe practice was acknowledged.

Mostly satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin. Dosage directions were received in writing. Obsolete directions had been cancelled and archived. Records of administration and stock balances were maintained on a separate recording sheet. It was noted that transcribed dosage directions had not been verified and signed by two registered nurses. The registered manager advised that this would be highlighted to all registered nurses for immediate corrective action. Due to the assurances provided an area for improvement was not specified at this time.

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.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicine refrigerators and oxygen equipment were checked at regular intervals. Satisfactory recordings were observed for the daily room and refrigerator temperatures.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

The majority of medicines examined had been administered in accordance with the prescriber's instructions. Some small discrepancies were discussed with the registered manager and registered nurse for ongoing monitoring.

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, fortnightly or three monthly medicines were due.

The management of distressed reactions, pain and dysphagia was reviewed and found to be satisfactory. One medicine which had recently been prescribed for "when required" administration was needed each morning. The registered manager advised that this would be referred to the prescriber for review.

The registered nurse advised 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.

The majority of medicine records were well maintained and facilitated the audit process. A small number of recently prescribed medicines had not been recorded on the personal medication records. The registered manager advised that this would be discussed with all registered nurses for ongoing attention. Due to the assurances provided an area for improvement was not specified at this time.

Practices for the management of medicines were audited throughout the month by staff and management. This included running stock balances for some medicines which were not contained within the blister pack system.

Following discussion with the registered manager and registered nurse and a review of the care plans, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice 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.

We observed the administration of medicines to a small number of patients at lunchtime. The registered nurse engaged the patients in conversation and explained that they were having their medicines.

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

We spoke with three patients who were complimentary regarding the care provided and the staff in the home. Comments included:

- "I am very happy here. The staff are very good to you. I like the food."
- "I like it here. I would never want to leave. The nurses give me my medicines and look after me. I get on well with everyone. The food is good. They always make sure that the cooks are good. Staff go to the shops for me if I ever need anything."

As part of the inspection process, we issued 10 questionnaires to patients and their representatives. Two relatives completed and returned the questionnaires. Their responses indicated that they were very satisfied with the care provided in the home.

Any comments from patients and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

Staff were observed to listen to patients and to take 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 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. Arrangements were in place to implement the collection of equality data within Arlington.

Written policies and procedures for the management of medicines were in place. They were not reviewed at the inspection.

Medicine related incidents reported since the last medicines management inspection were discussed and there was evidence of the action taken and learning implemented following these incidents. The registered nurse advised that he knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff advised that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by both staff and management. Areas identified for improvement were detailed in an action plan which was shared with staff to address and there were systems in place 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 advised that any concerns in relation to medicines management were raised with the registered manager.

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.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date.

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

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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