Unannounced Medicines Management Inspection Report
6 August 2018

Belmont

Type of Service: Nursing Home
Address: Parklands Close, 81 Tillysburn Park, Belfast, BT4 2PD
Tel No: 028 9076 3408
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 48 beds that provides care for patients with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual(s):** Dr Maureen Claire Royston	**Registered Manager:** See below
Person in charge at the time of inspection: Mrs Janice Brown	**Date manager registered:** Mrs Janice Brown – Acting – No application required
Categories of care: Nursing Homes (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:** 48

4.0 Inspection summary

An unannounced inspection took place on 6 August 2018 from 10.40 to 16.35.

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 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 medicine storage and the management of controlled drugs.

Areas for improvement were identified in relation to staff training, the management of warfarin and thickening agents, records of medication administration and receipt, and the governance arrangements for medicines management.

A follow up inspection will be planned to ensure that the areas identified for improvement are addressed and that the improvements are sustained.

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	3	2

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Janice Brown, 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 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 24 May 2018.

Enforcement action resulted 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

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

During the inspection the inspector met with one patient, one relative, two care assistants, three registered nurses, the resident experience care specialist, the regional manager and the manager.

We provided the manager with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We left 'Have we missed you' cards with the resident experience care specialist to display in a prominent area of the home. These cards 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 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
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 24 May 2018

The most recent inspection of the home was an unannounced follow up 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 24 June 2016

There were no areas for improvement identified as a result of the last medicines management inspection.

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.

The manager advised that medicines were managed by staff who have been trained and deemed competent to do so. Records of the training which had been completed within the last year were available for inspection. Competency assessments were available for six out of the eleven nurses employed. The findings of the inspection indicated that registered nurses on the first floor require further training and competency assessment on the procedures for managing medicines in Belmont. An area for improvement was identified.

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

There were systems in place to ensure that medicines were available for administration. Appropriate corrective action had been taken when a small number of medicines had recently been unavailable. 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. 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.
The management of warfarin was examined for two patients. Dosage directions had been received in writing and transcribed onto a separate administration recording sheet, not all transcriptions had been verified and signed by two registered nurses. Obsolete dosage directions had not been cancelled and archived and the current fax had been filed in the patients' notes. Running stock balances were maintained. Only the current dosage directions should be available on the medicines file. All transcriptions should be verified and signed by two registered nurses. An area for improvement was identified.

The management of insulin was reviewed. Records of prescribing and administration were clearly recorded. In-use insulin pens were stored at room temperature and the date of opening was recorded.

Appropriate arrangements were in place for administering medicines in food to assist swallowing. The prescriber had provided written authorisation and registered nurses advised that the pharmacist had been consulted to confirm the suitability of adding the medicines to food.

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 the management of insulin and controlled drugs.

Areas for improvement

Registered nurses should receive further training and competency assessment on the management of medicines.

The management of warfarin should be reviewed and revised.

	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.

The home had recently changed the medicine system. Several minor discrepancies in the administration of medicines and a significant audit discrepancy in the administration of one inhaled medicine were observed. Some audits could not be completed as records of medicines received into the home had not been accurately maintained (see below). The manager was requested to investigate the management of medicines for one patient, refer to the prescriber if necessary and inform RQIA of the outcome of the investigation. A robust audit system which includes the issues identified at this inspection should be implemented. An area for improvement was specified under Section 6.7.

The management of pain was reviewed and found to be satisfactory.

The management of distressed reactions was reviewed for two patients. Dosage instructions were recorded on the personal medication records. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. A detailed care plan and the reason for and the outcome of administration were recorded for only one of the patients. The registered nurse advised that this medicine had been prescribed recently for the second patient and that a care plan would be written immediately following the inspection and discussed with all registered nurses. Due to the assurances provided an area for improvement was not specified at this time.

The management of swallowing difficulty was examined for three patients. The prescribed thickening agent, including the recommended consistency level was clearly recorded on the personal medication records and diet notification sheets. Care plans and speech and language assessments were in place for only two of the three patients. Care assistants were not recording the administration of thickening agents. An area for improvement was identified.

Registered nurses 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.

An improvement in the standard of record keeping was necessary to ensure that there is a clear audit trail to evidence that medicines are administered as prescribed. Pre-printed medication administration records were in use. These were used to record the administration of medicines and receipt of medicines into the home. However, several duplicate records were available and records of medicines received into the home were not always recorded/could not be found. Clear records of medicines received into the home and administered should be maintained. An area for improvement was identified.

The layout of the medicines files was discussed and advice was given regarding filing the personal medication records adjacent to the medication administration records.

Following discussion with the manager and registered nurses, 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 management of pain.

Areas for improvement

The management of thickening agents should be reviewed and revised. Care plans should be in place and records of administration should be accurately maintained.

Medication administration records and records of medicines received into the home should be accurately maintained.

	Regulations	Standards
Total number of areas for improvement	2	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.

Arrangements were in place to facilitate patients responsible for the self-administration of medicines. It was agreed that a risk assessment would be put in place for one identified patient.

We observed the administration of medicines to a small number of patients. The registered nurses engaged the patients in conversation and explained that they were having their medicines. However, we observed that the registered nurse did not remain with one patient to ensure that the medicine had been taken. This was discussed with the registered nurse and manager and we were advised that all registered nurses were expected to ensure that they remained with patients until the medication had been taken.

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 one patient and one relative who were complimentary regarding the care provided and staff in the home. The relative commented:
" The staff are very good. We are happy with the care provided."

As part of the inspection process, we issued 10 questionnaires to patients and their representatives. Two relatives completed and returned the questionnaires within the specified time frame. 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 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.

	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 Belmont.

Written policies and procedures for the management of medicines were in place. The findings of the inspection indicate that not all registered nurses were familiar with the procedures for recording medicines received into the home. An area for improvement with regard to training and competency assessment was identified in Section 6.4.

The governance arrangements for medicines management were examined. A review of the weekly and monthly audits indicated that discrepancies in the administration of medicines and shortfalls in the management of medicines were not being identified by the current auditing system. At this inspection areas for improvement were identified in the domains of safe and effective care indicating that the auditing system was not robust. A robust audit tool should be implemented to ensure that medicines are being administered as prescribed on all occasions. The audit tool should cover all aspects of the management of medicine including those identified throughout this inspection. An area for improvement was identified.

There were arrangements in place for the management of medicine related incidents. The manager and registered nurses advised that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, the manager advised that staff were aware that medicine incidents may need to be reported to the safeguarding team. Medication related incidents reported since the last medicines management inspection were discussed.

Registered nurses advised that they could raise any concerns in relation to medicines management with management.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and management. One registered nurse advised that she felt more supported in her work recently.

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

Areas of good practice

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

Areas for improvement

The registered person should implement a robust audit tool to monitor the management of medicines.

	Regulations	Standards
Total number of areas for improvement	1	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 Mrs Janice Brown, 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 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 Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** 6 September 2018	The registered person should review and revise the management of thickening agents. Ref: 6.5
	Response by registered person detailing the actions taken: Clinical Lead is attending IDDIS Training on Stormont Hotel on 23rd October 2018. CA Training on Thickening Management will be delivered by the Resource Representative on 16th October 2018 and the Thick N Easy Representative on 12th October 2018. Supervisions and competency for CA staff has been commenced in regards to the recording of the use of thickening agents.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 6 September 2018	The registered person shall ensure that medication administration records and records of medicines received into the home are accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: All Central Prescription Records have been retyped. All medication received in the Home are receipted on the MARR sheet and all residents newly admitted are having their medications from home being recepited to enable the auditing process. This will be evidenced on the monthly medication audit.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 6 September 2018	The registered person should implement a robust audit tool to monitor the management and administration of medicines. Ref: 6.5 and 6.7
	Response by registered person detailing the actions taken: A daily medication audit has been commenced on the top floor which ensures every Resident's MARR and central prescription record is being audited over the month. A weekly medication audit is being completed on the ground floor. A monthly medication is being completed by the Clinical Lead or RE Team Faciliatator. All medication audits are linked to the Meridian Quality of Life system to ensure action and improvements are addressed.

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:** 6 September 2018	The registered person shall ensure that registered nurses receive further training and competency assessment on the management of medicines. Ref: 6.4
	Response by registered person detailing the actions taken: RN staff have commenced completing their SOAR Boots Patient Pack Online training. All are to be completed by the end of September Medication competancies are currently being undertaken or repeated with all of the RN staff.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 6 September 2018	The registered person shall review and revise the management of warfarin. Ref: 6.4
	Response by registered person detailing the actions taken: Warfarin confirmation management records from the GP Surgeries as discussed at the time of the inspection were available in the Home and have been returned to the medicine cardex files. Staff have been reminded to ensure that 2 RN staff are involved in any Warfarin discussions with the GP surgeries and the conversation is always followed up with a faxed confirmation. 2 staff signatures will be recorded in all change of prescriptions. The newly appointed Clinical Lead has taken responsibility for warfarin management on the top floor.

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

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