Unannounced Follow Up Medicines Management Inspection Report 23 October 2018

Windsor Care Home

Type of Service: Nursing Home
Address: 69 Osborne Park, Belfast, BT9 6JP
Tel No: 028 9066 5598
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 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 nursing home with 40 beds that provides care for patients with a range of care needs as detailed in Section 3.0.

3.0 Service details

Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Roulston	**Registered Manager:** See below
Person in charge at the time of inspection: Ms Josette Fernandez	**Date manager registered:** Ms Josette Fernandez , awaiting application, registration pending
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:** 40

4.0 Inspection summary

An unannounced inspection took place on 23 October 2018 from 11.00 to 14.30.

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 was undertaken in the intermediate care unit of the home due to the high number of medication related incidents which have been reported to RQIA. RQIA was concerned that although learnings from the incidents had been identified this had not driven the necessary improvement as incidents continued to occur.

The following areas were examined during the inspection:

- the governance arrangements for medicines management
- staffing - including induction, training and competency assessment
- the management of medicines on admission and medication changes
- the ordering and delivery systems for medicines
- the storage arrangements for medicines
- the management of warfarin, pain and thickening agents.

We spoke to two patients. Both were complimentary about the care provided and the staff in the home.

Evidence of good practice was found in relation to staff training, the management of medicines on admission, the standard of record keeping, the administration of medicines and care planning.

One area for improvement was identified in relation to the storage of medicines.

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	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Josette Fernandez, 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

The most recent inspection of the home was an unannounced care inspection undertaken on 6 June 2018. Other than those actions detailed in the QIP no further actions were required to be taken. 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.

During the inspection the inspector met with two patients, three registered nurses, the clinical lead nurse, the manager and the pharmacist.

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 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 6 June 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 2 November 2017

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

6.3 Inspection findings

The governance arrangements for medicines management

The current manager took up her position on 6 September 2018. Due to the high number of medication related incidents she completed an incident analysis and developed an action plan to drive improvement and minimise the likelihood of incidents occurring. The action plan was being implemented. Daily, weekly and monthly audits were completed.

Staffing - including training, induction and competency assessment

There had been a high reliance on agency staff and this was being addressed. A recruitment drive was undertaken and some positions had been filled. The duty rota had been reviewed to ensure that each shift was covered by both a permanent and agency registered nurse. The same agency nurses have been booked to provide continuity of care. All registered nurses, including agency staff, received a detailed induction and orientation in the home which included the management of medicines. Training and competency assessments were being updated.

The management of medicines on admission and medication changes

All patients were admitted from hospital with a discharge letter and a 28 day supply of their medicines. The personal medication records were written by one registered nurse and verified by a second registered nurse. The record was also reviewed by the pharmacist. Patients were seen by a doctor on the day of admission or the next day if the admission occurred in the evening. The doctor updated the personal medication records during their medicine rounds. Registered nurses were made aware of all medication changes following the round. Discontinued medicines were removed from use and newly prescribed medicines were ordered and received on the day that they were prescribed.

The ordering and delivery systems for medicines

The ordering and delivery systems for medicines were reviewed and revised following incidents where medicines were unavailable for administration and where medicines had not been handed over to a member of the nursing team on delivery. Medicines which were prescribed during a patient's stay in Windsor Care Home were ordered and received on the day that they were prescribed. Registered nurses on night duty requested repeat prescriptions for medicines when the current supply was at seven days remaining. Medicines were now delivered to the treatment room and the delivery note was signed by a registered nurse.

The storage arrangements for medicines

The medicines refrigerator, controlled drug cupboard and overstock were located in a small treatment room which was also used as the nurses' station. This room was very busy as several health care professionals visit the home each day. The medicine trolleys and medicines awaiting disposal were located in a cupboard beside the dining room. In order to minimise interruptions and to manage stock availability a larger treatment room used solely for medicines should be made available. An area for improvement was identified.

The management of warfarin

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. All transcribing involved two staff. Daily stock balances were maintained and the use of separate administration charts was acknowledged. The audits completed at the inspection indicated that warfarin had been administered as prescribed.

The management of pain

Pain assessments were completed as part of the admission process. Care plans were in place and they were updated following all reviews/changes in medication. Registered nurses were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. The clinical lead nurse advised that all current patients could verbalise any pain and a pain assessment tool was used as needed. The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed.

The management of thickening agents

A small number of patients were prescribed thickening agents. Care plans and speech and language assessment reports were in place. Details were recorded on the personal medication records and records of administration by registered nurses were maintained. Care assistants also administered thickening agents but records were not maintained. The clinical lead nurse advised that a recording system would be put in place from the day of the inspection onwards and that all care assistants would receive supervision. Due to the immediate action taken and the assurances provided an area for improvement was not identified.

Areas of good practice

There were examples of good practice found in relation to staff training, competency assessments, the management of medicines on admission, controlled drugs, the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

The storage arrangements for medicines should be reviewed and revised to ensure that a separate and suitable size room is made available.

	Regulations	Standards
Total number of areas for improvement	0	1

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 Ms Josette Fernandez, Manager, as part of the inspection process. The timescales for completion 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.

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) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time	The registered person shall review and revise the storage arrangements for medicines to ensure that there is sufficient storage space for medicines. Ref: 6.3
To be completed by: 23 November 2018	**Response by registered person detailing the actions taken:** While a suitable size room is not available yet, storage of medicines for the Intermediate care patients can be divided to both the First Floor Treatment room and the Lower Ground Floor Treatment Room. Medicines of patients in the Left wing of the Ground Floor can be stored in the Lower Ground Floor Treament room and the ones in the right wing of the Ground Floor will remain with the rest of the Intermediate patients' medicines in the First Floor.

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

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