Unannounced Medicines Management Inspection Report
22 November 2017

Beverly Lodge

Type of Service: Nursing Home
Address: 186a Bangor Road, Newtownards, BT23 7PH
Tel no: 028 9182 3573
Inspector: Paul Nixon

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 45 beds that provides care for patients living with dementia.

3.0 Service details

Organisation/Registered Provider: Ashdon Care Ltd **Responsible Individual:** Mr James Edward Russel Cole	**Registered Manager:** Mrs Janet Davison
Person in charge at the time of inspection: Mrs Janet Davidson	**Date manager registered:** 22 April 2010
Categories of care: Nursing Home DE – Dementia.	**Number of registered places:** 45 The home is also approved to provide care on a day basis to 2 persons

4.0 Inspection summary

An unannounced inspection took place on 22 November 2017 from 09.45 to 14.05.

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 medicine governance, medicine administration, medicines storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to medicine records.

The patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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	2

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Janet Davison, 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 most recent care inspection

Other than those actions detailed in the QIP, no further actions required to be taken following the most recent inspection on 12 May 2017.

5.0 How we inspect

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

- recent inspection reports and returned QIPs
- 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 we met with the registered manager, two registered nurses and one member of care staff.

A total of 10 questionnaires were provided for distribution to patients 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
- care plans
- training records
- medicines storage temperatures

Areas for improvements 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 12 May 2017

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 20 February 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must ensure that medicines requiring cold storage are maintained within the recommended temperature range.	**Met**
	Action taken as confirmed during the inspection: The daily medicine refrigerator temperature range recordings indicated that medicines requiring cold storage were maintained within the recommended temperature range.	
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 29 **Stated:** First time	The registered provider should ensure that administrations of thickening agents by the nursing staff are recorded.	**Met**
	Action taken as confirmed during the inspection: Examination of a random selection of medicine administration record sheets indicated that administrations of thickening agents by the nursing staff were recorded.	

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 had been trained and deemed competent to do so. An induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided in the last year.

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.

There were generally satisfactory arrangements in place to manage changes to prescribed medicines. However, personal medication records and handwritten entries on medicine administration records were sometimes not updated by two registered nurses. The registered manager gave an assurance that this matter would be rectified.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. The registered manager confirmed that all staff had attended safeguarding training.

There were procedures in place to ensure the safe management of medicines during a patient's admission or readmission to the home.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Additional medicines storage cupboards had been erected since the previous medicines management inspection. The medicine refrigerator and oxygen equipment were checked at regular intervals. However, insulin pens in current use did not have the patient's name and date of opening recorded. An area for improvement was identified.

Areas of good practice

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

Areas for improvement

An area for improvement was identified in relation to recording the patient's name and date of opening on Insulin pens.

	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 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.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. 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 care plan was maintained. However, for three patients whose records were examined, the reason for and the outcome of administration were generally not recorded. An area for improvement was identified.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. A pain assessment tool was used and a care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

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. Administrations were recorded and care plans and speech and language assessment reports were in place.

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.

Medicine records were mostly well maintained and facilitated the audit process. However, obsolete warfarin records belonging to one patient had not been archived. The registered manager gave an assurance that this matter would be rectified.

Practices for the management of medicines were audited throughout the month by management. This included running stock balances for many of the solid dosage medicines.

Following discussion with the registered manager and staff, 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 maintenance of the majority of medicine records, care planning and the administration of medicines.

Areas for improvement

An area for improvement was identified in relation to the recording of the reason for and the outcome of administration of medicines prescribed for administration on a "when required" basis for the management of distressed reactions.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

An observation exercise was completed at the start of the inspection. The inspector observed staff and patients in one of the lounges. All staff interactions with patients and relatives were positive and demonstrated that staff treated patients with dignity and respect. Staff were knowledgeable regarding patients' likes and dislikes. Staff were warm and welcoming to patients and visitors. 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.

The administration of medicines to patients was completed in a caring manner, the patient was given time to take their medicines and medicines were administered as discreetly as possible.

As part of the inspection process, we issued questionnaires to patients and their representatives. No questionnaires were returned within the specified timeframe.

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.

Written policies and procedures for the management of medicines were in place. They were not examined as part of this inspection.

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

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the registered manager, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that management were open and approachable and willing to listen.

No members of staff shared their views by completing an online questionnaire.

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 Mrs Janet Davison, 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 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 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 29 **Stated:** First time **To be completed by:** 22 December 2017	The registered person shall ensure that the patient's name and date of opening are routinely recorded on insulin pens. Ref: 6.4
	Response by registered person detailing the actions taken: Increased auditing scheduled to monitor the date of opening is recorded on insulin pens. Nursing staff reminded to record same. Pharmacist requested to place the residents label on the body of the pen.
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 22 December 2017	The registered person shall ensure that the reason for and the outcome of administration of medicines prescribed for administration on a "when required" basis for the management of distressed reactions are recorded. Ref: 6.5
	Response by registered person detailing the actions taken: Alternative 'user friendly' documentation implemented for the recording of the administration of 'when required' medications. Increased auditing scheduled to monitor same.

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

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