Unannounced Medicines Management Inspection Report
6 March 2018

Clifton Nursing Home

Type of Service: Nursing Home
Address: 2a Hopewell Avenue, Carlisle Circus, Belfast, BT13 1DR
Tel No: 028 9032 4286
Inspector: Rachel Lloyd

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 registered to provide care for up to 100 patients with a variety of healthcare needs.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individuals:** Mr Gavin O'Hare-Connolly	**Registered Manager:** Mrs Heather Lyttle
Person in charge at the time of inspection: Ms Hazel Batuto (Deputy Manager) Mrs Heather Lyttle arrived at 13.30	**Date manager registered:** 13 February 2018
Categories of care: Nursing Homes (NH): I – Old age not falling within any other category DE – Dementia PH – Physical disability other than sensory impairment	**Number of registered places:** 100 including: A maximum of 40 patients in category NH-DE and a maximum of four patients in category NH-PH.

4.0 Inspection summary

An unannounced inspection took place on 6 March 2018 from 09.45 to 16.25.

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 the storage of medicines, the management of controlled drugs, staff training and medicines governance and quality improvement.

Areas for improvement were identified in relation to the management of distressed reactions, recording the date of opening on medicines to facilitate audit, and ensuring that personal medication records and medication administration records correlate and reflect the prescriber's instructions.

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	1	*3

*The total number of areas for improvement includes two which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Heather Lyttle, 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 were required to be taken following the most recent inspection on 19 August 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 last medicines management inspection.

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

Medicines management in the Donegal and Benn units was examined during this inspection.

During the inspection we met with two patients, four registered nurses, two deputy managers and the registered manager.

Ten 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
- policies and procedures
- 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 19 August 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 23 February 2017

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13(4)

Stated: First time</td><td>The registered provider must ensure that the management of medicines requiring refrigeration is reviewed as detailed in the report.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

The management of these medicines had been reviewed since the last inspection and minimum, maximum and current temperatures were recorded on a daily basis in each unit. However, unsatisfactory minimum temperatures had been recorded between March and November 2017 for the refrigerator in the Donegal unit. Staff advised that since then the refrigerator and stock had again been replaced, staff had been trained in the use of the thermometer and were resetting this every day. The refrigerator and thermometer had also been replaced in the Toby Hurst unit. Staff were reminded of the importance of ensuring that temperatures remain in the required range of 2-8◦C and that action should be taken and recorded if deviations take place.</td></tr>
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	Due to the action taken and the assurances received from the staff and management this area for improvement was assessed as met and not stated for a second time.	
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 handwritten entries on medicine administration records are verified on every occasion.	**Met**
	Action taken as confirmed during the inspection: This was evidenced on the majority of records examined.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered provider should ensure that the disposal of medicines is reviewed as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: Procedures for the disposal of medicines were satisfactory.	
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time	The registered provider should ensure that the management of medicines administered "'when required" for distressed reactions is reviewed to ensure that the reason for and the outcome of administration are recorded on every occasion.	**Not met**
	Action taken as confirmed during the inspection: The reason for and the outcome of the administration of these medicines was not always recorded and although record sheets for this purpose were usually in place these were not used consistently. This area for improvement was stated for a second time.	

Area for improvement 4 **Ref**: Standard 30 **Stated:** First time	The registered provider should ensure that the date of opening is recorded on all medicines to facilitate audit.	**Not met**
	Action taken as confirmed during the inspection: The date of opening was not recorded on a number of prescribed medicines including all of the insulin pen devices in use, some of the medicines not included in the monitored dosage system and medicines prescribed for use "when required" such as analgesia and laxatives. Audit of these medicines was therefore not possible. This area for improvement was stated for a second time.	

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 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. The newly appointed registered manager advised that she was in the process of assessing training requirements. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Refresher training had been completed in the last year on medicines management, the management of PEG/PEJ tubes and syringe drivers and the management of dysphagia.

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

There were satisfactory arrangements in place to manage changes to prescribed medicines. The majority of personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

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

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.

Discontinued or expired medicines were disposed of appropriately. Staff confirmed that all relevant controlled drugs were denatured and rendered irretrievable prior to disposal. They were reminded that this detail should be clearly recorded in the record of disposal.

Appropriate arrangements were in place for administering medicines in disguised form.

Most of the medicines were stored safely and securely and in accordance with the manufacturer's instructions. Staff were reminded that one eye preparation in use should be refrigerated according to the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. The systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened were examined. Staff were reminded that insulin pen devices should be marked with the date of opening to prevent their use after expiry (see Section 6.2). Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, the management of medicines on admission and the management of 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 sample of medicines examined had mostly been administered in accordance with the prescriber's instructions. Some minor discrepancies were highlighted to staff for attention. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff as to when doses of weekly, monthly 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, 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. However, the reason for and the outcome of administration were not always recorded. A care plan was not always maintained. One new area for improvement was

identified in relation to care plans and an area for improvement identified at the last medicines management inspection was stated for a second time (see section 6.2).

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. Staff advised that most of the patients could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained.

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. Administration was 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.

Most of the medicine records were well maintained and facilitated the audit process. Some discrepancies between personal medication records and printed medication administration records were observed. These must correlate and accurately reflect the prescriber's instructions. An area for improvement was identified. A few missing signatures were observed on medicine administration records and this was highlighted for attention.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, regular audits were completed by the community pharmacist. The date of opening was not recorded on a number of prescribed medicines (see section 6.2). Audit of these medicines was therefore not possible. An area for improvement identified at the last medicine management inspection was stated for a second time. It was also discussed and agreed that the areas highlighted for attention in this report would be included in audit procedures.

Following observation, discussion with the staff and examination of records, it was evident that other healthcare professionals are contacted when required to meet the needs of patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the majority of the record keeping, audit procedures and communication between staff and other healthcare professionals.

Areas for improvement

Personal medication records and printed medication administration records must correlate and accurately reflect the prescriber's instructions.

The management of distressed reactions should be reviewed to ensure that a care plan is maintained.

Two areas for improvement identified at the last medicines management inspection, regarding the records maintained in relation to the management of distressed reactions and recording the date of opening on all medicines, were stated for a second time (see section 6.2).

	Regulations	Standards
Total number of areas for improvement	1	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.

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

Throughout the inspection, good relationships were observed between the staff and the patients. Staff were noted to be friendly and courteous.

The two patients spoken to at the inspection were complimentary about the management of their medicines and the care received in the home. 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.

Ten questionnaires were left in the home to facilitate feedback from patients and relatives. None were returned within the specified timescale (two weeks).

Areas of good practice

Good relationships were observed between staff and patients.

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 newly appointed registered manager was aware of and has started to address several of the issues highlighted at this inspection. This was acknowledged and plans for the further development of medicines governance in the home were discussed.

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

There were arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report 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 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 nurses and observation of interactions between registered nurses and care staff, it was evident that staff 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 management. They stated that there were good working relationships and that management were open and approachable and willing to listen.

Not all of the areas for improvement identified at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

No members of staff shared their views by completing the online questionnaire prior to the issue of this report.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to medicine governance arrangements and maintaining good working relationships. 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 Heather Lyttle, 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 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 April 2018	The registered person shall ensure that personal medication records and medication administration record sheets correlate and accurately reflect the prescriber's instructions. Ref: 6.5
	Response by registered person detailing the actions taken: All personal medication records and medication administration record sheets were checked on the day of inspection and action taken to ensure they correlated and accurately reflected the prescribers instructions .
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 18 **Stated:** Second time **To be completed by:** 6 April 2018	The registered provider should ensure that the management of medicines administered "'when required" for distressed reactions is reviewed to ensure that the reason for and the outcome of administration are recorded on every occasion. Ref: 6.2 & 6.5
	Response by registered person detailing the actions taken: Supervision has taken place with staff to ensure that staff understand the need for the outcome of administration to be recorded.
Area for improvement 2 **Ref**: Standard 30 Stated: Second time To be completed by: 6 April 2018	The registered provider should ensure that the date of opening is recorded on all medicines to facilitate audit. Ref: 6.2 & 6.5
	Response by registered person detailing the actions taken: Supervision has taken place with staff to ensure that all medications have a date of opening and this has been checked during audit.
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 6 April 2018	The registered person shall ensure that a care plan is maintained when a patient is prescribed medicines for the management of distressed reactions. Ref: 6.5
	Response by registered person detailing the actions taken: During the check for correlation of personal records and administration records these were cross referenced with careplans to ensure these are maintained

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

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