Unannounced Medicines Management Inspection Report
18 January 2018

Hillcrest Care Facility

Type of Service: Nursing Home
Address: 23 Old Mountfield Road, Omagh, BT79 7EL
Tel No: 028 8225 1222
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 76 beds that provides care for patients and residents with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Knockmoyle Lodge Ltd **Responsible Individual:** Mrs Linda Florence Becket, Registration pending	**Registered Manager:** Mrs Julie Ann Elizabeth Taylor
Person in charge at the time of inspection: Mrs Mary Early, Registered Nurse	**Date manager registered:** 1 October 2009
Categories of care: Nursing Home (NH) I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment Residential Care (RC) I – old age not falling within any other category DE – dementia	**Number of registered places:** 76 (comprising 56 nursing and 20 residential) Maximum of 44 persons in category NH-I, 12 persons in category NH-DE, 17 persons in category RC-DE and three persons in category RC-I. The home is also approved to provide care on a day basis to four persons.

4.0 Inspection summary

An unannounced inspection took place on 18 January 2018 from 09.55 to 15.00.

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 term ‘patients’ is used to describe those living in Hillcrest Care Facility which at this time provides both nursing and residential care.

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 staff training, competency assessment, the management of antibiotics and the majority of medicine records.

Areas requiring improvement were identified in relation to the admission process, the pre-dispensing of medicines and the monitoring of refrigerator and room temperatures.

The relative and patients we spoke with were complimentary about the management of their medicines and the care provided in the home.

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	0

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

Details of the Quality Improvement Plan (QIP) were discussed with the nurses in charge of each unit and with Mrs Julie Taylor, Registered Manager, via telephone call (31 January 2018), 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 26 September 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.

During the inspection we met with three patients, one relative, the administrator, four care assistants and three registered nurses.

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
- medicine audits
- care plans
- medicines storage temperatures
- controlled drug record book

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 26 September 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 12 and 13 September 2016

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**
rea for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered provider must ensure that robust arrangements are in place to facilitate the safe management of medicines during admission.	**Not met**
	Action taken as confirmed during the inspection: We reviewed the management of medicines on admission for two patients who had recently been admitted from their own homes. Their current medication regimens had not been confirmed in writing with the prescriber and records of receipt had not been maintained. This area for improvement was stated for a second time.	

Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered provider must ensure that robust arrangements are in place for the management of controlled drugs. **Action taken as confirmed during the inspection**: Robust arrangements were observed for the management of controlled drugs. They were stored in controlled drugs cabinets. Records of receipt, administration and disposal had been accurately maintained.	**Met**
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:** Second time	It is a recommendation that the registered person should ensure the medicines refrigerator is kept locked when not in use. **Action taken as confirmed during the inspection**: The medicines refrigerators were observed to be locked.	**Met**
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	The registered provider should review and revise the management and storage of oxygen cylinders. **Action taken as confirmed during the inspection**: The management of oxygen had been reviewed. Cylinders were chained securely and masks and tubing were covered.	**Met**
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time	The registered provider should ensure that medicine trolleys are chained to the wall when not in use. **Action taken as confirmed during the inspection**: Medicine trolleys were chained to the wall when not in use.	**Met**

Area for improvement 4 **Ref:** Standard 28 **Stated:** First time	The registered provider should ensure that written authorisation to administer medicines via enteral feeding tubes is obtained from the prescriber and the method of administration of each medicine should be detailed in the patient's care plan.	**Met**
	Action taken as confirmed during the inspection: Written authorisation to administer medicines via enteral feeding tubes had been obtained from the prescriber. The method of administration of each medicine was detailed in the care plan.	

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.

On the day of the inspection a glass containing strips with patients' names was observed in one treatment room. The registered nurse advised that medicines were sometimes pre-dispensed in order to save time. In addition some records of administration were being completed after the medicines round was finished rather than contemporaneously. These practices are unsafe. An area for improvement was identified. The registered manager gave assurances that this would be closely monitored.

The registered manager advised that all registered nurses completed training on the management of medicines via e-learning. Competency assessments were completed annually. An induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks. Refresher training on the management of medicines via the enteral route and rectal diazepam had been provided in the last year.

In relation to safeguarding, registered nurses advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. One medicine was omitted as it was out of stock on the day of the inspection, there was evidence that this was being followed up. 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 satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. This safe practice 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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. Obsolete dosage directions were cancelled and archived during the inspection.

Medicines were being crushed and administered in food to assist swallow for two patients in the Hillview unit. The prescribers had provided written authorisation for this practice. It was agreed that detailed care plans would be written. The registered manager confirmed (via telephone call, 31 January 2018) that the care plans were now in place.

The management of rectal diazepam for use in seizures was reviewed. Directions for use were recorded on the medicines labels. Care plans were in place but they did not provide sufficient detail. It was agreed that they would be updated following the inspection. The registered manager confirmed (via telephone call, 31 January 2018) that the care plans were now in place.

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; 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. Frequent omissions for the recordings of refrigerator temperatures were observed on the middle and top floors. In addition the room temperature was not being recorded in the treatment rooms. An area for improvement was identified.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the management of antibiotics.

Areas for improvement

One area for improvement regarding the management of medicines on admission was stated for a second time.

Medicines must not been pre-dispensed prior to administration. Records of administration must be completely immediately following the administration.

Refrigerator and room temperatures must be monitored and recorded each day to ensure that medicines are stored at the manufacturers' recommended temperatures.

	Regulations	Standards
Total number of areas for improvement	2	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. Discrepancies in two liquid medicines were observed, it was agreed that oral syringes would be used to measure liquids.

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, monthly or three monthly medicines were due. However, it was noted that one weekly medicine had not been administered on the morning of the inspection. This was investigated by the registered nurse and it was ascertained that a prompt had not been recorded in the diary. It was agreed that this would be discussed with all registered nurses and that the medicine would be administered the following morning.

The management of distressed reactions, swallowing difficulty and pain was reviewed. The relevant information was recorded in the patients' care plans, personal medication records and records of administration.

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.

With the exception of the records of medicines received for two patients, medicine records were well maintained and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by the staff and management. This included daily checks on nutritional supplements.

Following discussion with the registered nurses and care assistants, 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.

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 some patients over lunchtime. The registered nurse administering the medicines spoke to the patients in a kind and caring manner and the patients were given time to swallow 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. Staff assisting with lunch were encouraging patients to eat and were offering alternatives.

The patients spoken to at the inspection advised that they had no concerns in relation to the management of their medicines. They were complimentary regarding staff and management. Comments included:

- "It's wonderful here. There would be something wrong with you if you were not happy in this home."
- "I'm very happy here."

One relative commented:

- "My relative is being looked after well and has put on weight. I cannot praise this place enough, it is like a hotel. The staff are great."

As part of the inspection process, we issued ten questionnaires to patients and their representatives. Five patients and five relatives/representatives completed and returned questionnaires within the specified timeframe. Comments received were positive; with responses recorded as 'very satisfied' or 'satisfied' with the care provided in the home.

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; these were not reviewed at the inspection.

There were robust arrangements in place for the management of medicine related incidents. 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 satisfactory outcomes had been achieved. Registered nurses advised that if a discrepancy was identified it would be investigated and any learnings would be shared with all registered nurses for corrective action. The registered manager gave assurances that the management of medicines on admission and storage temperatures would be included in the home's audit processes.

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

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

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.

Several care assistants and the three registered nurses were complimentary about the management of the home and the standard of care. However, one member of staff commented that there should be more activities for patients. This comment was discussed with the registered manager for her attention and was also shared with the care inspector.

Part of the nursing home is currently in the process of being registered as a separate residential care home. The management of medicines is undertaken by trained and competent senior care assistants. The registered manager was advised that when the registration process was complete, discontinued and out of date medicines should be returned directly to the community pharmacist for disposal.

Areas of good practice

There were examples of good practice in relation to 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 Julie Taylor, 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:** Second time **To be completed by:** 18 February 2018	The registered provider must ensure that robust arrangements are in place to facilitate the safe management of medicines during admission. Ref: 6.2
	Response by registered person detailing the actions taken: Staff advised to follow policy regarding medications on admission.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 18 February 2018	The registered person shall ensure that medicines are not pre-dispensed prior to administration and that records of administration are completed contemporaneously. Ref: 6.4
	Response by registered person detailing the actions taken: Registered nurses spoke to re: administration, recording and importance of following NMC guidelines.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 18 February 2018	The registered person shall ensure that refrigerator and room temperatures are accurately monitored and recorded each day to evidence that medicines are stored at the recommended temperatures. Ref: 6.4
	Response by registered person detailing the actions taken: Refrigerator and room temperatures are recorded daily. Auditing in place to monitor. Staff spoken to re: importance of recording.

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

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