Unannounced Medicines Management Inspection Report
14 March 2018

Bannview House Care Home

Type of Service: Nursing Home
Address: 23 Bannview Road, Banbridge, BT32 3RL
Tel No: 028 4066 0110
Inspector: Judith Taylor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 80 beds that provides care for patients and residents living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Amore (Warrenpoint) Limited **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager:** Mrs Cherith Rogers
Person in charge at the time of inspection: Mrs Cherith Rogers	**Date manager registered:** 29 January 2018
Categories of care: Nursing Homes (NH): DE – Dementia I – Old age not falling within any other category PH – Physical disability other than sensory impairment Residential Care Home (RCH): I – Old age not falling within any other category	**Number of registered places:** 80 comprising: - 41 patients in category NH-DE - a maximum of 15 patients in NH-I - two patients in category NH-PH - a maximum of 22 residents in RC-I

4.0 Inspection summary

An unannounced inspection took place on 14 March 2018 from 10.05 to 14.55.

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 Bannview House Care Home, which at this time provides both nursing and residential care.

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 the governance arrangements, training and competency assessment, management of medicine changes, medicine storage and controlled drugs.

Areas requiring improvement were identified in relation to the completion of medicine records and care plans.

Patients were noted to be relaxed and comfortable in their surroundings and in their interactions with staff. The patients we met with spoke positively about their care and their well-being. We noted the warm and welcoming atmosphere 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	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Cherith Rogers, 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 2 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 was displayed to inform visitors to the home that an inspection was being conducted.

During the inspection we met with two patients, two registered nurses, one member of care staff and the registered manager.

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

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.

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 2 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 3 January 2017

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.

Medicines were managed by staff who have 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. A sample of records was provided at the inspection. Refresher training in medicines management was provided in the last year. In relation to safeguarding, staff 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. 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. Personal medication records and handwritten entries on medication administration 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 and insulin. Written confirmation of dosage regimes was in place and care plans were maintained.

Epilepsy management plans were in place for medicines which were required to be administered in the event of seizures.

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

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. 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.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines changes, medicine storage and 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.

With the exception of a few medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. These medicines were highlighted at the inspection. We were assured that these medicines would be closely monitored within the audit process.

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. Reminder alerts were in place on the administration records and a separate list was also maintained.

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. A care plan was maintained for some but not all of the patients prescribed these medicines. An area for improvement in relation to care planning was identified. 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. There was evidence that when there was an increase in frequency of use, this was referred to the prescriber for review. The reason for and the outcome of the administration were usually recorded. It was agreed that staff would be reminded to record this on every occasion.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. A care plan was maintained for some but not all of the patients prescribed these medicines. An area for improvement in relation to care planning was identified. 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. Staff also advised that a pain assessment was completed as part of the admission process.

The management of swallowing difficulty was examined. Most of the details were recorded on the patient's personal medication records and care plans. One personal medication record required some further information and this was being addressed at the inspection. It was noted that the one care plan did not reflect the most recent speech and language assessment report and some of the records of administration did not clearly indicate if thickened fluids had been administered. An area for improvement was identified. Following discussion with staff, it was concluded that the correct fluid consistency was being administered to the patients and that they were aware of the recent changes.

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. Areas of good practice were acknowledged. They included separate administration records for high risk medicines and transdermal patches, and protocols for 'when required' medicines. However, in relation to the records pertaining to external preparations, these were not fully and accurately maintained and there was no evidence of any monitoring of these records. An area for improvement was identified.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines which were not contained within the 28 day blister packs and also the stock balance of medicines carried forward to the next medicine cycle. This good practice was acknowledged. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs.

Areas of good practice

There were some examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The necessary arrangements should be made to ensure that patients' care plans are up to date and reflect their current healthcare needs in relation to distressed reactions, pain management and swallowing difficulty.

The administration of thickening agents should be closely monitored to ensure that records are fully maintained.

The management of external preparations should be reviewed to ensure that robust arrangements are in place.

	Regulations	Standards
Total number of areas for improvement	0	3

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 completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible. The registered nurse explained the medicine and encouraged the patients to take 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 they were familiar with the patients' likes and dislikes.

We met with two patients, who expressed their satisfaction with the care, the staff and the registered manager. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were adhered to. Comments included:

"I am happy to be here."
"I am getting on well."
"The girls are nice."

We noted the warm and welcoming atmosphere in the home and the decorations in relation to St Patrick's Day and Easter. Some patients had been to or where attending the hairdresser on the morning of the inspection.

Of the questionnaires which were left in the home to facilitate feedback from patients and their representatives, five were returned within the timeframe (two weeks). The responses indicated

that they were very satisfied with the care provided in the home. Four comments were made and shared with the registered manager and also with the care inspector:

"Could not be any better, care is excellent in Downshire at Bannview."
"It is a very good care home and (patient) enjoys living here."
"Staff are excellent but I think they are overworked at times. Additional staff would be in the interests of everyone, especially the residents."
"Staff excellent but need more of them. Far too busy and no time to run to all of the patients."

Areas of good practice

Staff listened to patients 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 examined at the inspection. 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 robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. The registered manager provided details of the action taken and the changes in practice which had been implemented. 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 robust governance process to oversee medicines management was in place. Daily audit reports were reviewed by management. These reports readily identified any areas for improvement and there was evidence that issues were reported and addressed in a timely manner. The registered manager also advised of the organisation's risk register which was reviewed per shift by management, whereby clinical risk was assessed in terms of a traffic light system, red, amber or green to highlight daily priorities.

There were effective communications systems in the home to ensure that all staff were kept up to date. The shift handovers were verbal and written and a sample of the written handover sheet was observed. The registered manager advised that a meeting was also held every morning with the unit managers/head of departments in the home. In relation to medicines

management, this meeting was used to inform staff of new admissions, discharges, medicine changes, dietary requirements, audits and incidents as required.

The registered manager stated that she completed a walk around of each unit every morning and used the outcomes of the written handover report to ensure any issues were addressed. She advised that this walk around also enabled her to view the administration of medicines.

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 any resultant action was communicated through team meetings, supervision or individually with staff. They advised that management were open and approachable and willing to listen; and stated that there were good working relationships within the home and with healthcare professionals involved in patient care. Comments included:

“This is a great home to work in.”
“The manager and staff are brilliant.”
“I enjoy my work.”

During the inspection we discussed the processes in relation to part of the nursing home being registered as a separate residential care home. The registered manager confirmed that this process was underway and in relation to medicines management, this would continue to be undertaken by trained and competent care staff. She also confirmed that following completion of this registration process, all staff would be made aware of the procedures for the safe disposal of medicines in residential care homes and that medicines would be returned directly to the community pharmacist for disposal.

There were no online questionnaires were completed by staff within the specified timeframe (two weeks).

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 Cherith Rogers, 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 14 April 2018	The registered person shall ensure that patients' care plans reflect their current healthcare needs in relation to distressed reactions, pain management and swallowing difficulty. Ref: 6.5
	Response by registered person detailing the actions taken: The identified care plans were changed to reflect the residents current needs within 24hours of the inspection. This has been added as an area to check on the Medication Quality Walk Round to ensure that it is completed for all residents.
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 14 April 2018	The registered person shall closely monitor the records in relation to the administration of thickening agents to ensure these are fully maintained. Ref: 6.4
	Response by registered person detailing the actions taken: A review of thickneing agents, administation and documentation has been carried out. Daily documentation checks are in place to enusre that the records are fully maintained. This has been added as an area to check on the Medication Quality Walk Round to ensure that it is completed for all residents.
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 14 April 2018	The registered person shall closely monitor the management of external preparations to ensure that robust arrangements are in place. Ref: 6.5
	Response by registered person detailing the actions taken: The management of external preparations has been reviewed and new processes and checks put in place. This has been added as an area to check on the Medication Quality Walk Round to ensure that it is completed for all residents.

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

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