Unannounced Medicines Management Inspection Report
24 May 2016

Bohill House

Type of Service: Nursing Home
Address: 69 Cloyfin Road, Coleraine, BT52 2NY
Tel No: 028 7032 5180
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Bohill House took place on 24 May 2016 from 10.20 to 15.40.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern. A Quality Improvement Plan (QIP) has not been included in this report.

Is care safe?
No requirements or recommendations have been made.

Is care effective?
No requirements or recommendations have been made.

Is care compassionate?
No requirements or recommendations have been made.

Is the service well led?
No requirements or recommendations have been made.

This inspection was underpinned by 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.

Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

For the purposes of this report, the term 'patients' will be used to described those living in Bohill House which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Tracey Henry, Registered Manager, as part of the inspection process and can be found in the main body of the report.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the most recent inspection on 24 February 2016.

2.0 Service details

Registered organisation/registered person: Priory Care Homes No. 2 Ltd / Mrs Caroline Denny	**Registered manager:** Mrs Tracey Henry
Person in charge of the home at the time of inspection: Mrs Tracey Henry	**Date manager registered:** 15 August 2011
Categories of care: RC-DE, NH-I, NH-DE, NH-PH	**Number of registered places:** 80

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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 indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

We met with three patients, two registered nurses, three members of senior care staff, the maintenance person, and two visitors.

A sample of the following records was examined:

- 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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 February 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 24 November 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must closely monitor the administration of citalopram drops. Any further discrepancies should be investigated and reported to RQIA.	**Met**
	Action taken as confirmed during the inspection: There was evidence that a specific audit tool had been developed and implemented for citalopram drops. A daily stock balance was maintained and checked by management.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must ensure that robust arrangements are in place for the management of external preparations.	**Met**
	Action taken as confirmed during the inspection: The management of external preparations had been reviewed. Separate records had been implemented for care staff to record administration. The completion of these records was overseen by the registered nurses. The sample of administration records examined had been well maintained. A few record entries which required updating were discussed and addressed at the inspection.	

Requirement 3 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must make the necessary arrangements to ensure that all medicines are available for administration as prescribed. **Action taken as confirmed during the inspection**: The evidence indicated that patients had a continuous supply of their medicines. The registered manager advised of the procedures in place to ensure that all medicines were held in stock.	**Met**
Last medicine management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37, 38 **Stated:** First time	The registered manager should closely monitor the administration of liquid medicines to ensure the medicine administered as prescribed. **Action taken as confirmed during the inspection**: The registered manager had implemented a separate audit sheet for liquid medicines and running stock balances were maintained. The evidence indicated that liquid medicines had been administered as prescribed.	**Met**
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered manager should review the management of distressed reactions to ensure the relevant records are maintained. **Action taken as confirmed during the inspection**: There was improvement in the management of records for distressed reactions. Details of prescribing and administration were clearly recorded. Protocols had been implemented for anxiolytic medicines for most of the patients prescribed these medicines and a distressed reaction chart had also been implemented. Some care plans were not in place. This was discussed with the registered manager who advised that this would be addressed with immediate effect. Due to the assurances provided by the registered manager, this requirement was assessed as met.	**Met**

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for registered nurses, senior care staff 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 completed through attendance at training sessions and the completion of e-learning modules. The most recent training was in relation to syringe drivers. The registered manager advised that update training in the management of dementia and pain management was to be planned in the near future.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. A copy of the prescription was kept in the home. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

There were robust procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home. Written confirmation of medicine regimes was obtained for the sample of new patients' records examined.

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. The use of separate administration charts was acknowledged.

Appropriate arrangements were in place for administering medicines in disguised form and the management of medicines which were administered via an enteral feeding tube.

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 for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

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, fortnightly 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. The reason and outcome of the administration were recorded. A care plan was maintained for most of the patients. The registered manager assured that this would be addressed with immediate effect, to ensure these were maintained for all the relevant patients. Although staff advised they 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 pain controlling medicine had been requested for one patient in the last week, however, had not been followed up with the prescriber. This was discussed at length and was being addressed during the inspection.

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 also advised that a pain assessment was completed for each patient as part of the admission process. The reason for the administration of pain relief was recorded e.g. headache, backache and this good practice was acknowledged. Staff advised that most of the patients could verbalise pain, and a pain assessment tool was used as needed. However, for one patient who could not verbalise pain and there had been some changes in behaviour, it could not be confirmed how this patient would express pain and it could not be ascertained if the patient was in pain. The registered manager confirmed by email on 25 May 2016 that this patient's care plan and pain management plan had been updated and the pain assessment tools would also include picture cards to assist patients communicating pain, where necessary.

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. Each administration was recorded and care plans and speech and language assessment reports were in place. One recent change had yet to be implemented on the patient's medicine records; however, the staff confirmed they had been made aware of the new fluid consistency and were administering the correct fluid consistency. It was agreed that these records would be updated by the end of the day. This was confirmed in the email received by RQIA on 25 May 2016.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for transdermal patches, analgesics and liquid medicines; and a separate record book was maintained for antibiotics.

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.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to issues or concerns regarding medicines management. The registered manager provided recent examples of where this had occurred.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

The administration of medicines to a small number of patients was observed at the inspection. It was found that the medicines were administered in a caring manner and as discreetly as possible. The patients were given time to take their medicines.

The patients spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines, and their request for medicines prescribed on a 'when required' basis was adhered to.

Following discussion with the patients they stated:
'The staff were very good.'
'The staff couldn't be any better.'
'I'm quite content what they do here.'

The relatives of a patient advised that they were very pleased with the care in the home and the treatment and attention provided to their relative.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. The registered manager advised that these were reviewed every few years and the most recent update was in September 2015. The registered manager advised that all staff had been made aware of these and this was confirmed following discussion with staff.

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. There was evidence of the action taken and learning implemented following incidents. Staff confirmed that they had been made aware of medicine related incidents.

It was noted that management and staff were very knowledgeable regarding the individual patient needs with respect to medicines.

A comprehensive auditing process for medicines management had been developed since the last inspection and there was evidence that this had been well embedded into routine practice. Practices for the management of medicines were audited throughout the month by the registered nurses and senior care staff. The audits included running stock balances for several solid dosage medicines, liquid medicines and inhaled medicines and review of medicine records and medicine equipment. In addition, a quarterly audit was completed by the community pharmacist. The audit process was readily facilitated by recording the date of opening on medicines and also recording the quantity of medicine carried forward from the last medicine cycle. 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. No discrepancies were observed in the outcomes of the audit trails performed at the inspection.

The requirements and recommendations made at the last medicines management inspection had been addressed. This demonstrated a robust response to regulation.

It was observed that there was a lot of activity in one of the nursing units. The registered manager advised that she had reviewed the deployment of staff to enable the registered nurses to administer the patients' medicines on time, especially around meal times.

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

Staff advised that management were open and approachable and willing to listen. They stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

It was observed that there were effective communication systems in place. As well as written handover reports, verbal handovers were completed at the end of each shift. In addition, a daily head of department meeting was held, which included a representative from the nursing unit, residential unit, laundry, kitchen and maintenance department. In relation to medicines management, this meeting was used to inform staff of new admissions, discharges, changes in medicines, dietary requirements, audit discrepancies and incidents.

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.

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. The most recent meetings regarding medicines management had been held earlier this month. The registered manager advised of the agenda items which involved medicines management.

It was acknowledged that robust systems for medicines management had been developed and implemented. The evidence indicated that this has promoted the delivery of positive outcomes for patients.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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 registered person/manager from their responsibility for maintaining compliance with the regulations and standards.

The Regulation and Quality Improvement Authority

9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews