Unannounced Medicines Management Inspection Report
8 November 2017

Bohill House

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

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 living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Amore (Ben Madigan) Limited **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager:** Mrs Tracey Henry
Person in charge at the time of inspection: Mrs Tracey Henry	**Date manager registered:** 15 August 2011
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category DE – Dementia PH – Physical disability other than sensory impairment Residential Care Homes (RC) DE – Dementia	**Number of registered places:** 80 comprising: - Maximum 26 – NH-I - Maximum 36 – NH-DE - 1 identified patient – NH-PH - 18 – RC-DE

4.0 Inspection summary

An unannounced inspection took place on 8 November 2017 from 09.50 to 16.15.

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 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 for medicines, medicines administration, the standard of record keeping and the management of controlled drugs.

An area for improvement was identified in relation to the management of insulin.

Patients and relatives spoke positively about 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	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Tracey Henry, 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 9 August 2017.

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, two relatives, four staff, and the registered manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff, for completion and return to RQIA.

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

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 9 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 24 May 2016

There were no areas for improvement made 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 or more frequently, as needed. A sample of records was provided. Refresher training in the management of medicines, dementia, enteral feeding, dysphagia, syringe drivers and safeguarding was provided in the last year. The registered manager also advised of the training provided through the In Reach Training Programme and the internal designated nurse champions in relation to medicines management.

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 and for the management of medicine changes. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

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

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.

The management of high risk medicines e.g. warfarin and insulin was reviewed. Written confirmation of prescribed dosage regimes was in place. Separate administration records were in use, which is good practice. However, the records of administration for insulin were discussed. One record indicated that the incorrect dose was administered on two occasions; however, a corresponding record indicated that the correct dose had been administered. The registered manager investigated this after the inspection and provided details that these were recording errors and the patient had been administered the correct dose. The registered manager confirmed the format of the insulin chart had been redesigned and implemented after the inspection, to ensure that the administration of different insulins could be clearly recorded.

Appropriate arrangements were in place for administering medicines in disguised form. A care plan was maintained.

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

Medicine storage areas were clean, tidy and well organised. The medicines were stored safely and securely and in accordance with the manufacturer's instructions. It was noted that an injectable medicine had been drawn up, but had not been required. This remained in the medicines refrigerator. This was discussed and disposed of during the inspection.

The management of limited shelf medicines was examined. Robust systems were in place to manage eye preparations. However, in relation to in use insulin pen devices, one had passed the expiry date and was replaced during the inspection; the date of opening was not recorded on one other insulin pen device, and whilst it was acknowledged that the supply would be completed before the 28 day expiry date, the need to record the date was discussed. An area for improvement in relation to the management of insulin was identified.

Medicine refrigerators and oxygen equipment were checked on a daily basis.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, supervision and appraisal, adult safeguarding, the management of medicines on admission and medicines changes, and controlled drugs.

Areas for improvement

The management of insulin should be monitored in relation to record keeping and storage.

	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.

With the exception of two liquid medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. The registered manager provided assurances that these would be included in the audit process.

There were robust arrangements in place to alert staff of when doses of early morning medicines, time critical medicines, weekly medicines and three monthly medicines were due; details were recorded on whiteboards displayed in the treatment rooms and also marked out on the patient's medication administration records.

On occasion, some medicines were required to be crushed prior to administration. This was recorded in the patient's care plan. Consent had been obtained from the prescribers.

The management of distressed reactions was reviewed. Four patients' records were examined. The medicine and dosage instructions were recorded on their personal medication records and individual protocols. 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. These medicines were rarely required to be administered. Staff confirmed that when administered the reason for and the outcome of administration were recorded. With the exception of one patient, a care plan was in place. The registered manager confirmed this care plan would be written after 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 advised that some of the patients could tell staff if they were in pain, and confirmed that a pain assessment tool was used as needed. A care plan was maintained in each of the patients' records examined and included their pain assessment. They were evaluated on a monthly basis or more frequently as needed.

The management of swallowing difficulty was examined. Three patients' records were examined. The thickening agent was recorded on their personal medication records and included details of the fluid consistency. Systems were in place to remind staff which patients were required to have fluids thickened. Care staff confirmed that this system worked well. Records of administration were maintained. Care plans and speech and language assessment reports were in place for two of the patients. The registered manager provided assurances that this this would be addressed for the other patient by the end of the day.

The management of medicines administered via an enteral feeding tube was reviewed. The prescribed feeding regime was in place and details were recorded on the patient's personal medication record. A record of the administration of food, fluids and medicines was recorded. Whilst it was acknowledged that the target fluid intake was achieved each day, the layout of the form was discussed and it was agreed that this would be reviewed to ensure that the total fluid intake was recorded. The registered manager confirmed by email that a new format of fluid intake chart had been implemented on 9 November 2017.

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 well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for antibiotics, transdermal patches and protocols for medicines prescribed on a 'when required' basis.

Practices for the management of medicines were audited throughout the month by the staff. This included running stock balances for several medicines which were not supplied in the 28 day blister packs, this included nutritional supplements and liquid medicines. This is good practice.

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

Areas of good practice

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

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.

The administration of medicines to patients was completed in a caring manner and patients were given time 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 the staff were familiar with the patients' likes and dislikes.

The patients we met with spoke positively about their care and the management of their medicines. They were complimentary regarding staff and management. Comments included:

"Staff are all very good."
"They listen to us."
"I am happy here and feel content."
"I couldn't say anything but good things about this home."

One patient made a few comments regarding meal choices and this was shared with the registered manager for her attention and follow up.

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.

We met with two relatives and they also spoke positively about the care provided. Comments included:

"The whole family are more than happy with the staff and care here."
"The staff are busy but very good; they keep us informed."
"Care is 110%, couldn't ask for better."

Of the questionnaires which were left in the home to facilitate feedback from patients, staff and relatives, three were returned from patients, one from a patient's representative and three from staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines. One comment regarding care was made and shared with the registered manager for her attention and follow up. This was also shared with the care inspector.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the staff listening to and taking account of the views of 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.

Written policies and procedures for the management of medicines were in place. These were not examined in detail. We were informed that these were reviewed regularly and any updates were shared with staff. Staff confirmed they were aware of the policies and procedures.

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. Management advised of the review of staff competency and the supervision completed post incident, to ensure that any learning was implemented. A sample of records was provided. 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.

There were robust governance arrangements in place for medicines. In addition to the staff audits, management completed a monthly audit. A quarterly audit was completed by the community pharmacist and an annual audit was completed by a designated person from the organisation. Medicines management was also reviewed as part of the daily management 'walk rounds' throughout the home. It was clear from discussion with staff and management and a review of records, that any areas identified through internal and external audit were addressed in a timely manner. Examples of where practice had changed were provided.

The registered manager advised of the communications systems in place to ensure that staff were kept up to date regarding new patients, new medicines/medicine changes and other issues. We were informed that shift handover was verbal and written; and a head of department meeting was held each morning.

Following discussion with the registered manager and 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. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

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 Tracey Henry, 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 28 **Stated:** First time **To be completed by:** 9 December 2017	The registered person shall closely monitor the management of insulin. Ref: 6.4
	Response by registered person detailing the actions taken: The dates of opening of Insulin pens has been highlighted on the "dry wipe boards" within the treatment rooms and covered as part of supervision with the qualified staff. This will continue to be monitored through internal audit process.

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

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