Unannounced Medicines Management Inspection Report
11 December 2017

St James' Lodge Care Home

Type of Service: Nursing Home
Address: 15 - 17 Coleraine Road, Ballymoney, BT53 6BP
Tel No: 028 2766 8212
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 44 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: St. James' Lodge Limited **Responsible Individual:** Mr Francis Donal McKenna	**Registered Manager:** Miss Bronagh Barker
Person in charge at the time of inspection: Miss Bronagh Barker	**Date manager registered:** 4 October 2013
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:** 44 comprising: NH-I - 21 NH-DE - 20 NH-PH - 3 The home must not admit any patients into bedrooms 40, 41, and 42 until a full assessment of their nursing needs (including mobility) has been undertaken and the specified bedrooms are deemed suitable to meet their assessed needs.

4.0 Inspection summary

An unannounced inspection took place on 11 December 2017 from 10:10 to 14:45.

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, training, the standard of record keeping and management of controlled drugs.

Areas requiring improvement were identified in relation to storage, medicines administration and the management of distressed reactions.

Patients spoke positively about the management of their medicines and the care provided to them. There was a 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 Miss Bronagh Barker, 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 15 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, three staff and the registered manager.

A total of 10 questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completion of 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
- care plans
- training records
- medicines storage temperatures
- policies and procedures

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 15 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 20 January 2017

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. Refresher training in medicines management was provided on an annual basis. A sample of training records, supervision and competency records was made available at the inspection. The registered manager also discussed the training provided within the In Reach training programme via the Northern Health and Social Care Trust, which included the management of diabetes, syringe drivers, enteral feeding, Parkinson's and subcutaneous fluids.

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.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training was completed within the last year.

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.

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. The management of limited shelf life medicines once opened should be reviewed. Whilst the date of opening was recorded on all insulin pens and eye preparations in current use, three expired eye preparations were removed for disposal. An area for improvement was identified. The medicine refrigerator was checked on a daily basis and oxygen equipment was checked at weekly intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, supervision and competency assessment, the management of new medicines and controlled drugs.

Areas for improvement

The management of eye preparations should be reviewed to ensure that these are not administered after their expiry date.

	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.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. A small number of discrepancies were observed in liquid and inhaled medicines. These were discussed with the registered manager. An area for improvement was identified.

There was evidence that time critical medicines had been administered at the correct time, such as early morning medicines and medicines prescribed at weekly or three monthly intervals.

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. 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. The reason for and the outcome of administration were not routinely recorded. An area for improvement was identified.

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. Staff also advised that a pain assessment was completed as part of the admission process.

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.

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 transdermal patches, high risk medicines and double signatures for the writing and updating of personal medication records and medication administration records.

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 supplied in the 28 day blister packs, and recording the quantity of medicines carried forward to the next medicine cycle. This good practice readily facilitated the audit process and was acknowledged. A quarterly audit was also completed by the community pharmacist.

Following discussion with the registered manager and staff and a review of the 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 most medicines, the general standard of record keeping and care planning. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The administration of the identified medicines should be closely monitored to ensure they are administered as prescribed.

The management of distressed reactions should be reviewed to ensure that the reason for and the outcome of the administration of medicines is recorded on each occasion.

	Regulations	Standards
Total number of areas for improvement	0	2

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. The patients were encouraged to take their medicines and given the necessary time to swallow their medicines. The medicines were administered as discreetly as possible.

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.

We met with three patients. They spoke positively about the staff and management. Their comments included:

"I get on very well here, I have no complaints."
"There is always good chat."
"The food is quite good, I really enjoy the Sunday dinner."
"The staff are very kind and do look after you."

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.

Of the ten questionnaires which were left in the home to facilitate feedback from patients and their representatives, two were returned within the time frame. The responses indicated that they were very satisfied with all aspects of the care provided. No staff questionnaires were completed within the specified timeframe.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing patients 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. Staff advised that they were familiar with them and were kept up to date of any changes.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how incidents were shared with them to inform learning and change of practice, if necessary. 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. The registered manager advised that team meetings and supervision were used to share any areas for improvement identified through the audit process and any incidents which had occurred.

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 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 found throughout the inspection in relation to governance arrangements, management of medicine incidents, quality improvement and maintaining good working relationships.

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 Miss Bronagh Barker, 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:** 11 January 2018	The registered person shall review the management of eye preparations as detailed in the report. Ref: 6.4
	Response by registered person detailing the actions taken: A new management of eye preparations plan has commenced & all staff made aware.
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 11 January 2018	The registered person shall develop a system to ensure that liquid medicines and inhaled medicines are closely monitored to ensure these are administered as prescribed. Ref: 6.5
	Response by registered person detailing the actions taken: Robust audit/monitoring of liquid & inhaled medicines has commenced + will be ongoing.
Area for improvement 3 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 11 January 2018	The registered person shall review the systems in place for the management of distressed reactions to ensure that details of administration are fully recorded. Ref: 6.5
	Response by registered person detailing the actions taken: Staff reminded of the importance of recording any medicines administered to minimise distressed reactions & outcomes of same.

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

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