Unannounced Medicines Management Inspection Report
20 January 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

1.0 Summary

An unannounced inspection of St James' Lodge Care Home took place on 20 January 2017 from 10.25 to 14.45.

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.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. There were systems in place to ensure that the management of medicines was in compliance with legislative requirements and standards. No requirements or recommendations were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure that patients were receiving their medicines as prescribed. Specific areas of medicines management were detailed in the patients' care records. No requirements or recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. Patients consulted with confirmed that they were administered their medicines appropriately. There were no requirements or recommendations made.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. No requirements or recommendations were 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.

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 Miss Bronagh Barker, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 14 November 2016.

2.0 Service details

Registered organisation/registered person: St James' Lodge Limited/ Mr Francis Donal McKenna	**Registered manager:** Miss Bronagh Barker
Person in charge of the home at the time of inspection: Miss Bronagh Barker	**Date manager registered:** 4 October 2013
Categories of care: NH-I, NH-PH, NH-DE	**Number of registered places:** 44

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

We met with two patients, one member of care staff, two registered nurses, the registered provider and the registered manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

A sample of the following records was examined at the inspection:

- 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

Twenty-five questionnaires were issued to patients, relatives/representatives and staff with a request, that these were completed and returned within one week of the inspection.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 November 2016

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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection 9 December 2015

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must ensure that cefalexin oral suspension is discarded at expiry.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that all staff were aware of the expiry date of this medicine. A few bottles were opened and remained within the in use expiry date. There was evidence in the disposal records that this medicine had been discarded once the expiry date had been reached.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time	The registered manager should ensure that the reason for each administration and the subsequent outcome are recorded for medicines which are prescribed to be administered "when required" for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: A review of patient's care files indicated that a record of the reason for and outcome of administration of these medicines had been recorded.	

Recommendation 2 **Ref**: Standard 18 **Stated:** First time	The registered manager should ensure that detailed care plans are in place for the management of distressed reactions and that the regular use of "when required" medicines is referred to the prescriber for review.	**Met**
	Action taken as confirmed during the inspection: Care plans were in place and there was evidence that any ongoing administration was reported to the prescriber for review.	

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 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 the management of medicines, Parkinson's, dementia and diabetes had been provided in the last year.

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. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home.

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 format of the warfarin administration records in use was commended.

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. Staff were reminded that external preparations should be kept in the outer original container where possible. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The medicine refrigerator 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 majority of medicines examined had been administered in accordance with the prescriber's instructions. Some discrepancies in liquid medicines were noted and discussed. The registered manager provided assurances that they would be closely monitored. She confirmed by email on 24 January 2017 that she had developed and implemented an audit sheet for liquid medicines. A sample format was provided.

The registered manager advised of the ongoing programme of medication review in consultation with the trust pharmacist and general practitioners, to improve medicine management needs of patients.

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.

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. 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 recorded. A care plan was maintained.

The management of pain was examined. Staff advised that a pain assessment was completed for all patients at the time of admission to the home and on a regular basis. The patient's pain management was detailed in the sample of care plans examined. The sample of records examined indicated that pain controlling medicines had been administered as prescribed. Staff were aware of the need to ensure that the pain was well controlled and the patient was comfortable.

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.

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 the patients' healthcare needs.

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 patients was completed in a caring manner; patients were given time to take their medicines and medicines were administered as discreetly as possible.

Following discussion with staff, it was clear that the staff were familiar with the patients' needs, their likes and dislikes.

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.

The patients spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests for pain relief or care. This was evidenced during the inspection. The patients were very complimentary regarding the care provided by the staff and the registered manager. Their comments included:

"They are very good to me here."
"Staff couldn't look after me any better."
"I'm happy here."

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.

As part of the inspection process, questionnaires were issued to patients, relatives/patients' representatives and staff. Seven questionnaires were completed and returned by one patient, three relatives/patient's representatives and three members of staff. The responses were recorded as 'very satisfied' or 'satisfied' with medicines management in the home.

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. Management advised that these were reviewed regularly and would be used as part of the supervision process. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to 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.

A variety of internal auditing systems were in place for medicines management. They included daily, weekly and monthly audits. An overarching audit was completed by management monthly or quarterly; and in addition audits were completed by the community pharmacist. A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where areas for improvement had been identified, an action plan was developed and shared with staff to read, address and sign. These were also discussed at staff meetings.

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.

The staff spoken to at the inspection were very positive about their work, the relationships between staff and the support provided by the staff team and the registered manager. They were very complimentary regarding the leadership in the home and advised that the registered manager was always available and willing to listen.

One questionnaire response stated:

"Bronagh is an excellent, very approachable and very organised manager."

Staff confirmed that any concerns in relation to medicines management were raised with management.

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 provider from their responsibility for maintaining compliance with the regulations and standards.

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