Inspection Report
17 September 2020

Deanfield

Type of Service: Nursing Home
Address: 19 Deanfield, Limavady Road, Londonderry, BT47 6HY
Tel No: 028 7134 4888 / 028 7134 1754
Inspector: Rachel Lloyd

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home registered to provide nursing care for up to 28 patients.

2.0 Service details

Organisation/Registered Provider: Loughview Homes Ltd **Responsible Individuals:** Mr Paul Steel Mr Michael Curran	**Registered Manager and date registered:** Mrs Joy McLaughlin 13 December 2007
Person in charge at the time of inspection: Ms Ciara McHugh (Deputy Manager)	**Number of registered places:** 28
Categories of care: Nursing Home (NH) I – Old age not falling within any other category	**Number of patients accommodated in the nursing home on the day of this inspection:** 25

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 17 September 2020 from 10.30 to 13.20. Short notice of the inspection was provided on the morning of the inspection in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

This inspection focused on medicines management within the home and also assessed progress with any areas for improvement identified at or since the last medicines management inspection.

Progress in any areas for improvement identified at or since the last care inspection will be assessed at the next care inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information and any other written or verbal information received.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home with regard to the management of medicines
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept.

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug record book
- care records regarding medicines management
- medicine audits.

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Ciara McHugh, Deputy Manager, as part of the inspection process and can be found in the main body of the report.

5.0 What has this service done to meet any areas for improvement identified at or since the last medicines management and care inspection on 10 October 2019?

Areas for improvement from the last medicines management/care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 27 (4)(b) **Stated:** Second time	The registered person shall take adequate precautions against the risk of fire to ensure the safety and wellbeing of patients in the home. Specific reference to ensuring that fire doors are not propped/held open.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: No fire doors were observed to be propped/held open on the ground floor. This area for improvement will be carried forward for full validation at the next care inspection.	
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall ensure that medicines are stored securely at all times.	**Met**
	Action taken as confirmed during the inspection: All medicines were stored securely. The medicine trolleys were locked and secured to the wall. Medicine cupboards and the door to the medicines storage area were locked and the keys held securely by the nurse in charge. The two registered nurses spoken to confirmed that this is routine practice.	

6.0 What people told us about this service

On the day of inspection we spoke to the two registered nurses on duty. They expressed satisfaction with how the home was managed and stated that they found their work fulfilling. They also said that they had the appropriate training to look after patients and meet their needs.

All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

We did not speak to patients on this occasion, although good interactions were observed between staff and patients. Staff were warm and friendly and obviously knew the patients well. A group of patients were seated in the outside area enjoying some music in the sun with a member of staff.

7.0 Inspection findings

7.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This may be done by the GP or the pharmacist.

All patients in the home were registered with a local GP and medicines were reviewed and dispensed by the community pharmacist.

Personal medication records were in place for each patient. These contained a list of all prescribed medicines with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals e.g. medication reviews, transfers to hospital. These records had been fully and accurately completed. In line with best practice a second member of staff had checked and signed these records when they were updated to provide a double check that they were accurate.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Care plans were in place and directions for use were clearly recorded on the personal medication records. The reason for and outcome of the administration were recorded in the daily care records.

Satisfactory systems were in place for the management of pain.

7.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines must be available to ensure that they are administered to patients as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

The records inspected showed that medicines were available for administration when patients required them. The registered nurses on duty advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage area was observed to be securely locked. It was tidy and organised so that medicines belonging to each patient could be easily located. Storage had been reviewed and records archived appropriately in a new filing cabinet to create more space as had been previously advised. The medicines currently in use were stored within medicine trolleys that were also securely stored so that there could be no unauthorised access. Controlled drugs were stored in a controlled drug cabinet. When medicines needed to be stored at a colder temperature, they were stored within the medicine refrigerator and the temperature of the refrigerator was monitored.

Medicine disposal was discussed. Controlled drugs were denatured appropriately and discontinued medicines were not allowed to accumulate in the home. Disposal of medicine records had been completed so that medicines could be accounted for.

7.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Medicine administration records are completed when medicines are administered to a patient. A sample of these records was reviewed and found to have been fully and accurately completed.

The manager and registered nurses audit medicine administration on a regular basis within the home. With two exceptions, the audits showed that medicines had been given as prescribed. These two discrepancies were minor and indicated that only occasionally one tablet/capsule may have been administered when two were prescribed. This was discussed with the deputy manager and it was agreed that where two tablets/capsules are prescribed for one dose, that this should be highlighted on the personal medication records/label as a reminder for staff. It was also agreed that this would be checked during audit procedures. The date of opening was recorded on the majority of medicines so that they could be easily audited; this is good practice.

Audits completed during this inspection showed that medicines had been administered as prescribed.

7.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

We reviewed the management of medicines on admission to the home for one patient. A hospital discharge letter had been received and a copy had been forwarded to the patient's GP.

The personal medication record had been accurately written. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

7.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place that quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. There had been no medication related incidents identified since the last medicines management inspection. The deputy manager was familiar with the type of incidents that should be reported and advised that learning from audits was shared with staff.

7.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported.

Records were not examined on this occasion; however the registered nurses on duty confirmed that staff in the home receive a structured induction which includes medicines management when that forms part of their role. Competency is assessed following induction and annually thereafter and a written record completed.

8.0 Evaluation of Inspection

This inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led regarding the management of medicines.

The outcome of this inspection concluded that the area for improvement identified at the last medicines management inspection had been addressed and no new areas for improvement were identified.

We can conclude that patients and their relatives can be assured that medicines are well managed within the home.

We would like to thank the patients and staff for their assistance throughout the inspection.

9.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care