Unannounced Medicines Management Inspection Report
30 November 2017

Greenhaw Lodge Care Centre

Type of Service: Nursing Home
Address: 42 Racecourse Road, Londonderry, BT48 8DA
Tel No: 028 7135 4725
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 which is registered to provide nursing care for up to 42 persons as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Larchwood Care Homes (NI) Ltd **Responsible Individual:** Mr Christopher Walsh	**Registered Manager:** Miss Ronagh McCaul
Person in charge at the time of inspection: Ms Ruth McKeown (Staff Nurse) until 14.20 and Miss Ronagh McCaul thereafter	**Date manager registered:** 7 March 2012
Categories of care: Nursing Homes (NH) DE – Dementia A – Past or present alcohol dependence	**Number of registered places:** 42

4.0 Inspection summary

An unannounced inspection took place on 30 November 2017 from 10.35 to 15.30.

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 general governance arrangements, the standard of record keeping and care planning, the administration of medicines and management of controlled drugs.

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

Patients spoke positively about the management of their medicines and their care 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 Miss Ronagh McCaul, 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 1 June 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 two patients, two relatives, two registered nurses, the activities co-ordinator and the registered manager.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to record 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
- policies and procedures
- 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 1 June 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 2 February 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. Competency assessments were completed annually. Refresher training in medicine management, dysphagia and dementia had been completed 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. 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 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.

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

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. Staff were reminded that when the complete stock of a controlled drug was disposed of or transferred out of the home, the stock balance should be brought to zero. 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. A care plan was maintained.

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. In one treatment room, some of the medicine cupboards were not locked due to problems with the doors. We were assured that there was no unauthorised access to this locked room. The registered manager advised that she would report this within the organisation for corrective action. This was also shared with the RQIA estates inspector and care inspector.

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 of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

With the exception of some liquid medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. These medicines were highlighted to staff and management. The registered manager gave an assurance that these medicines would be closely monitored from the day of the inspection onwards.

There were satisfactory arrangements in place to alert staff of when time critical medicines must be administered, such as early morning medicines and also medicines which were prescribed at weekly or fortnightly intervals. However, it was noted that bisphosphonate medicines were signed as administered at the same time as other medicines. Following discussion with staff we were assured that these medicines were given separately from food or other medicines. It was agreed that all staff would be reminded to record the actual time of administration on each occasion.

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. The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. A care plan was maintained. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. There was evidence that pain was assessed on a daily basis. Staff advised that some of the patients could verbalise pain, and a pain assessment tool was used as needed. Staff also advised that a pain assessment was completed as part of the admission process.

On occasion some medicines were required to be administered in disguised form. This was recorded in the patient's care plan. Consent had been obtained from the prescriber.

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. However, in relation to the prescribed fluid consistency for one patient, the care plan, administration record and personal medication record did not correlate. Staff provided details of recent changes. The registered manager provided assurances that the records would be updated by the end of the day.

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. They advised that most patients took their medicines as prescribed and provided examples of where the prescriber had been contacted to change the formulation and/or time of administration of medicines, to assist with the patient's compliance.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of separate administration records for transdermal patches, high risk medicines and injections; 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 a quarterly audit was completed by the community pharmacist.

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 a small number of medicines to patients was observed at the inspection. The patients were given plenty of time to swallow their medicines.

Following discussion with staff they provided examples of when medicines were administered at a later or earlier time to facilitate the patients' preferences/needs; and confirmed that they were aware of and adhered to the prescribed time intervals between 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:
"I get on well here."
"It's good staff."
"I love the music."
"The staff get me what I need."

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. They advised us that they were content with everything, the staff were good and they had no concerns about anything.

Although we left questionnaires to facilitate feedback from patients and their representatives, and invited staff to complete an online questionnaire, no questionnaires had been returned or completed at the time of issuing the report.

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. Although we were advised of the procedures in place to manage any areas identified for improvement, we noted some discrepancies in liquid medicines as mentioned in Section 6.5. There was evidence that these had been identified within the audit process; however, there was no evidence of the action taken and they had not been shared with the registered manager. An area for improvement was identified.

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

Areas for improvement

The system to report audit outcomes to management should be reviewed.

	Regulations	Standards
Total number of areas for improvement	0	1

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 Ronaugh McCaul, 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:** 30 December 2017	The registered person shall review the auditing systems in place in relation to reporting and managing audit outcomes. Ref: 6.7
	Response by registered person detailing the actions taken: Pharmacy audits will be signed off by the Home Manager. Action plans will be created and followed up in the next month's audit.

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

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