Unannounced Medicines Management Inspection Report
23 April 2018

Edenvale Care Home

Type of Service: Nursing Home
Address: 1-7 Edenmore Road, Limavady, BT49 0RF
Tel No: 028 7772 2055
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 55 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: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** See box below
Person in charge at the time of inspection: Mrs Katrina Canning-Service	**Date manager registered:** Mrs Katrina Canning-Service (Acting Manager – no application required)
Categories of care: Nursing Homes (NH): DE - Dementia I - Old age not falling within any other category LD - Learning disability MP - Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH - Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI -Terminally ill	**Number of registered places:** 55 including: NH-DE - a maximum of 21 patients NH-LD - one patient NH-MP- two patients NH-MP(E) - two patients NH-PH - four patents NH-TI - six patients

4.0 Inspection summary

An unannounced inspection took place on 23 April 2018 from 10.20 to 15.50.

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 some good practice was found in relation to the governance arrangements for medicines management, the administration of medicines, the completion of records, medicines storage and the management of controlled drugs.

Areas for improvement were identified in relation to the management of out of stock situations, pain management and medicines prescribed on a “when required” basis.

Patients spoke positively about the management of their medicines and their care in the home. They were complimentary about the staff. They were observed to be relaxed and comfortable 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 Mrs Katrina Canning-Service, Manager, and by telephone with Mrs Louisa Rea, Regional Manager, Four Seasons Health Care, on 24 April 2018, 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

No further actions were required to be taken following the most recent inspection on 12 December 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 four patients, three registered nurses, one care assistant and the manager.

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

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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 12 December 2017

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 20 October 2016

There were no areas for improvement identified 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.

The manager confirmed that 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 medicines management was also completed annually. Other training included the management of dementia and swallowing difficulty. A sample of training records and competency assessments was provided for review. Due to the inspection findings as detailed below, the regional manager advised that a staff meeting with registered nurses would be scheduled.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home. Written confirmation of medicines regimes was obtained at or prior to admission.

We were advised of the systems in place for the stock control of medicines to ensure that adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay and there were safe arrangements

for the storage of prescriptions. However, the stock balance records indicated that a pain relieving patch had been out of stock on two occasions and had not been administered as prescribed; it had been administered two days late on one occasion and had been missed on another occasion. This had not been reported to the manager. An area for improvement was identified. See also Sections 6.5 and 6.7.

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. Training was completed annually.

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. insulin.

A small number of patients may require their medicines to be crushed and administered in disguised form. Staff confirmed the policy for this. One patient's records were examined and a care plan was in place.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Staff were reminded that the disposal record should clearly indicate that controlled drugs have been denatured.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. 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 in relation to staff training, competency assessment, the management of medicines on admission and the storage of medicines.

Areas for improvement

The stock control of medicines should be reviewed to ensure that all medicines are available for administration and any out of stock medicines are reported to the manager.

	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 a few medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. The records indicated that for two patients there was regular administration of night sedation medicines which were prescribed for occasional use. This should be reported to the prescriber for review. An area for improvement was identified.

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 twice weekly and weekly medicines were due. These were marked out on the medication administration records.

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 recorded on most occasions. The records indicated that these medicines were being administered on a regular basis for one patient. This should be referred to the prescriber.

The management of pain was examined. Staff advised of the systems in place to ensure that each patient's pain was monitored and the patient was comfortable. This was assessed at the time of the admission to the home and on a daily basis. A care plan was maintained. A review of records indicated that most of the patients' pain relieving medicines had been administered as prescribed. However, as stated in Section 6.4, this was not observed for one patch and it was found that the corresponding medication administration records and stock balance records did not correlate. An area for improvement was identified.

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. Records of administration, 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.

Overall, the majority of medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for high risk medicines, oral nutritional supplements, transdermal patches and "when required" medicines such as laxatives and analgesics. However, a small number of personal medication records required updating and this was being addressed by the registered nurses during the inspection. In relation to the legibility of records, the handwriting on a small number of records was difficult to read. Management provided assurances that this would be addressed with immediate effect.

Practices for the management of medicines were audited throughout the month by the staff and management. This included daily running stock balances for tablets, capsules, nutritional supplements, some liquid medicines and inhaled medicines. Staff had also recorded the stock balance of medicine carried forward to the next medicine cycle. This is good practice was acknowledged. In addition, a quarterly audit was completed by the community pharmacist.

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

Areas of good practice

There were some examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

The regular administration of medicines which are intended for occasional or "when required" use should be referred to the prescriber for review.

The management of pain for one identified patient should be investigated and a written report of the findings and action taken should be forwarded to RQIA.

	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, patients were given time to take their medicines and medicines were administered as discreetly as possible. On occasion, the medicines were administered at a later time as the patient preferred to sleep later in the morning.

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 they were familiar with the patients' likes and dislikes.

We met with four patients, who expressed their satisfaction with the care and the staff. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were adhered to. Comments included:

"I am happy enough here and don't have any concerns."
"The staff get me what I need."
"I'm getting on ok."
"I enjoy the food, there is plenty of it."
"The girls look after me."

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 questionnaires which were left for patients and their representatives, none were returned within the specified time frame (two weeks). Any comments in questionnaires received after the return date will be shared with the manager for their information and action as required.

Areas of good practice

Staff listened to patients and took account of their views.

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.

The inspector discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The manager confirmed that there were arrangements in place to implement the collection of equality data within Edenvale Care Home.

Written policies and procedures for the management of medicines were in place and readily available for staff. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

The management of medicines related incidents was discussed. We were advised of the arrangements in place to ensure that all staff knew how to identify and report incidents, and how all staff were made aware of incidents, to prevent recurrence. However, as there had been apparent out of stock situations and these had not been reported to management, the need to review incident management was discussed. See Section 6.4. 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 sample of the internal medicines management audit records was reviewed. Where a discrepancy had been identified, there were systems in place to share with staff and implement new procedures as necessary. The outcomes of the most recent management audit undertaken earlier this month had identified several areas for improvement and these were listed in an action plan. This was currently being addressed by management and staff.

Following discussion with management, 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 any resultant action was communicated through team meeting and supervision. Staff advised that they felt well supported in their work and that there were good working relationships in the home.

No online questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements 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 Katrina Canning-Service, Manager, and Mrs Louisa Rea, Regional Manager, Four Seasons Health Care, 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 the 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	The registered person shall review the stock control of medicines to ensure that all medicines are available for administration and that any out of stock situations are reported to the manager. Ref: 6.4 & 6.7
To be completed by: 23 May 2018	**Response by registered person detailing the actions taken:** The GP was contacted and the pain patch for one identified resident has now been brought into line with the monthly cycle. The GP prescribed one extra patch. Supervision has been carried out with all Registered Nurses in relation to reporting any out of stock medication to the Home Manager in person or on the 24 hour shift report.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that the regular administration of medicines which are prescribed for occasional/"when required" use, is referred to the prescriber for review. Ref: 6.5
To be completed by: 23 May 2018	**Response by registered person detailing the actions taken:** A full review of all as and when required medications has taken place. The nursing staff have contacted the various Health Centres to review these. One resident who was prescribed as and when night sedation the GP has now prescribed the medication on a regular basis. The other resident had the night sedation reviewed by the GP and this has now been discontinued.
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the management of pain for one identified patient and forward a written report of the findings and action taken. Ref: 6.4 & 6.5
To be completed by: 23 May 2018	**Response by registered person detailing the actions taken:** See attached report.

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

The Regulation and Quality Improvement Authority

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

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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