Unannounced Medicines Management Inspection Report
23 February 2018

Oakmont Lodge Care Home
Nursing Unit

Type of Service: Nursing Home
Address: 267 - 271 Old Belfast Road, Bangor, BT19 1LU
Tel No: 028 9146 5822
Inspector: Helen Daly

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 29 beds that provides care for patients with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Maria Mallaband (9) Limited **Responsible Individual:** Mrs Victoria Craddock	**Registered Manager:** See box below
Person in charge at the time of inspection: Ms Juliet Green	**Date manager registered:** Ms Juliet Green 'Acting' – application not yet submitted
Categories of care: Nursing Homes I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years	**Number of registered places:** 29

4.0 Inspection summary

An unannounced inspection took place on 23 February 2018 from 10.00 to 14.50.

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 good practice was found in relation to medicines administration, medicine records, storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to the management of medicines on admission/re-admission and records for the administration of thickening agents.

The patient we spoke with was complimentary about the care provided 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	1	1

Details of the Quality Improvement Plan (QIP) were discussed with Ms Juliet Green, 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 28 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 one patient, two care assistants, one registered nurse and the manager.

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.

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 28 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 26 May 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. All registered nurses had attended medicines management training provided by the community pharmacist recently. Training on medicines management was also completed annually via e-learning. Competency assessments were completed following induction and annually thereafter. Care assistants had received training on the administration of thickening agents and emollient preparations.

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

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. 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. One discontinued medicine was available for administration. There was no evidence that it had

been administered. The registered nurse advised that it was “on hold” rather than discontinued and removed it from the trolley.

Improvements in the procedures to ensure the safe management of medicines during a patient’s admission/re-admission to the home were found to be necessary. Some records of medicines received into the home had not been adequately maintained. Two supplies of the same medicines were available and in use for two patients. This increases the risk of a medicine being administered twice and does not provide a clear audit trail. An area for improvement was identified.

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. It was agreed that a bound book would be used to record the shift handover checks.

Mostly satisfactory arrangements were in place for the management of insulin. Records of prescribing and administration were clearly maintained. However it was noted that directions on one label had been over-written by one registered nurse. It was agreed that a line would be drawn through obsolete dosage directions on the label and that registered nurses would be directed to the current directions on the personal medication record.

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. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The temperature of the medicine refrigerator and treatment room were monitored daily and were within the accepted range.

Appropriate arrangements were in place for administering medicines in disguised form.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of controlled drugs and the storage of medicines.

Areas for improvement

The management of medicines on admission/re-admission to the home should be reviewed and revised. Clear records of medicines received should be maintained and only one supply of each medicine should be in use at any one time.

	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.

The sample of medicines examined had been administered in accordance with the prescriber's instructions. As stated in Section 6.4, some audits could not be completed as more than one supply of each medicine was in use.

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 medicines were due.

The management of distressed reactions and pain was reviewed. The relevant information was recorded in the patients' care plans, personal medication records and records of administrations.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record and medication administration records. Care plans and speech and language assessment reports were in place. Care assistants had access to the most up to date reports; however, they were not maintaining records of administration. An area for improvement was identified.

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. This was evidenced for two patients during the inspection.

The majority of the medicine records were well maintained and facilitated the audit process. As stated in Section 6.4 records of some medicines received into the home on admission/re-admission had not been adequately maintained.

Practices for the management of medicines were audited throughout the month by staff and management. This included running stock balances for medicines which were not supplied in the monitored dosage system. In addition, a quarterly audit was completed by the community pharmacist. Following discussion with the manager and registered nurse, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had excellent working relationships with healthcare professionals involved in patient care.

Areas of good practice

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

Areas for improvement

Records of administration of thickening agents must be maintained.

	Regulations	Standards
Total number of areas for improvement	1	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 medicines to patients had been completed prior to the commencement of this inspection and was not observed. Staff were knowledgeable about the administration of medicines and guidance was displayed on the medicines file for easy reference.

Appropriate arrangements were in place to facilitate patients responsible for the self-administration of their 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 patient spoken to at the inspection was enjoying lunch and chatting to care assistants. He appeared happy and did not raise any issues.

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, we issued ten questionnaires to patients and their representatives. One patient's representative completed and returned a questionnaire within the specified timeframe. They were 'satisfied' with the care provided in the home.

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.

Written policies and procedures for the management of medicines were in place.

There were robust arrangements in place for the management of medicine related incidents. Medicine related incidents reported since the last medicines management

inspection were discussed. There was evidence of the action taken and learning implemented. In relation to the regional safeguarding procedures, the manager confirmed that staff were aware that medicine incidents may need to be reported to the safeguarding team.

Following discussion with the manager, registered nurse and care assistants, 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.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents 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 Ms Juliet Green, 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 the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** 23 March 2018	The registered person shall ensure that records for the administration of thickening agents are accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: The Home Manager has implemented specific document ie Food Additive Record – Thickeners for resident who requires thickening agent. This form is introduced for care staff to maintain record of administration. This record is completed by competent care staff and checked by the registered nurse in charge and cross referenced with the prescribed thickener on the MARR sheet and drug kardex.
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:** 23 March 2018	The registered person shall ensure that the management of medicines on admission/re-admission to the home is reviewed and revised. Ref: 6.4 and 6.5
	Response by registered person detailing the actions taken: The Home Manager carried out supervision with registered nurses on medication management focussing in maintaining, retaining and auditing of medication supply for resident newly admitted or re admitted. The Home Manager continues to carry out medication audit which covers medication stock/storage and any actions arising are addressed within the set timescale.

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

Assurance, Challenge and Improvement in Health and Social Care