The Regulation and Quality Improvement Authority

Inspection Report
6 October 2020

Knockmoyle Lodge

Type of Service: Nursing Home
Address: 29 Knockmoyle Road, Omagh, BT79 7TB
Tel No: 028 8224 7931
Inspector: Paul Nixon

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 which is registered to provide care for up to 35 patients living with dementia.

2.0 Service details

Organisation/Registered Provider: Knockmoyle Lodge **Responsible Individual:** Mrs Linda Florence Beckett	**Registered Manager and date registered:** Mrs Sharon Margaret Colhoun 30 January 2020
Person in charge at the time of inspection: Mrs Sharon Margaret Colhoun	**Number of registered places:** 35 The home is also approved to provide care on a day basis for one person.
Categories of care: Nursing Home (NH) DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 34

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 6 October 2020 from 09.40 to 12.40.

Short notice of the inspection was provided to the manager 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. The inspection also assessed progress with any areas for improvement identified since the last care inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections 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
- 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 records
- care plans
- governance and audit
- staff training and competency records
- medicine storage temperatures

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 Mrs Sharon Margaret Colhoun, 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.

5.0 What has this home done to meet any areas for improvement identified at the last care inspection on 9 January 2020?

Areas for improvement from the last care inspection		
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 24 **Stated:** First time	The registered person shall ensure that all complaints received: • provide the date/time received • the name of the person who received the complaint • provide whether or not the complainant is satisfied with the outcome	**Met**
	Action taken as confirmed during the inspection: The complaints record was reviewed. The required information was recorded.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that all nursing interventions are appropriate to the individual patients needs and supported by current evidence and best practice guidelines. Specific reference to repositioning and dietary/fluid intake recording charts and care plans: • The frequency of repositioning should be recorded within the repositioning chart to reflect the patients care plan • Dietary type and fluid consistency should be recorded on daily intake charts to reflect the patients care plan and direct relevant care.	**Met**
	Action taken as confirmed during the inspection: The repositioning care plans and repositioning charts for three patients were reviewed. For each patient, the frequency of repositioning recorded within the repositioning chart correlated with that specified in the care plan.	

	The dietary/fluid intake recording charts for three patients were reviewed. For each patient, the dietary type and fluid consistency recorded on the daily intake charts reflected the patient's care plan and directed relevant care.	

6.0 What people told us about this home?

We met with the manager and two registered nurses. Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs. Staff were warm and friendly and it was evident from their interactions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. Six questionnaires were returned from patients or their relatives within the timeframe for inclusion in this report. The respondents stated that they were very satisfied with all aspects of care. No members of staff responded to the online questionnaire within the timeframe for inclusion in the report.

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 will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the pharmacist or during a hospital admission.

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

Personal medication records were in place for each patient. These are records used to list all the 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, hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate.

Copies of patients' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets, etc.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for three patients. 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. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. Records of administration were clearly recorded. The reason for and outcome of administration were generally recorded in the daily progress notes.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required.

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

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

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

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Controlled drugs were stored in the controlled drug cabinet. When medicines needed to be stored at a colder temperature, they were stored within the medicine refrigerator and the temperature of this refrigerator was monitored.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

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.

Within the home, a record of the administration of medicines is completed on medicine administration records when medicines are administered to a patient. A sample of these records was reviewed and were found to have been fully and accurately completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in a controlled drug record book. We found that controlled drugs were safely managed in the home and that records were accurately maintained.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on medicines so that they could be easily audited. This is good practice.

The audits completed during this inspection showed that medicines had been given 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 for two recently admitted patients. Written confirmation of prescribed medicines had been obtained as part of the admission process. In each instance, the patient's personal medication record had been accurately written. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate.

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 which 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. Management and staff were familiar with the type of incidents that should be reported.

There had been no medicine related incidents reported to RQIA since the last medicines management inspection.

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.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

Records of staff training in relation to medicines management were available for inspection.

8.0 Evaluation of Inspection

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

We can conclude that medicines were well managed and the patients were being administered their medicines as prescribed by their GP.

The outcome of this inspection also concluded that all areas for improvement identified at the last care inspection had been addressed. No new areas for improvement were identified.

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.

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