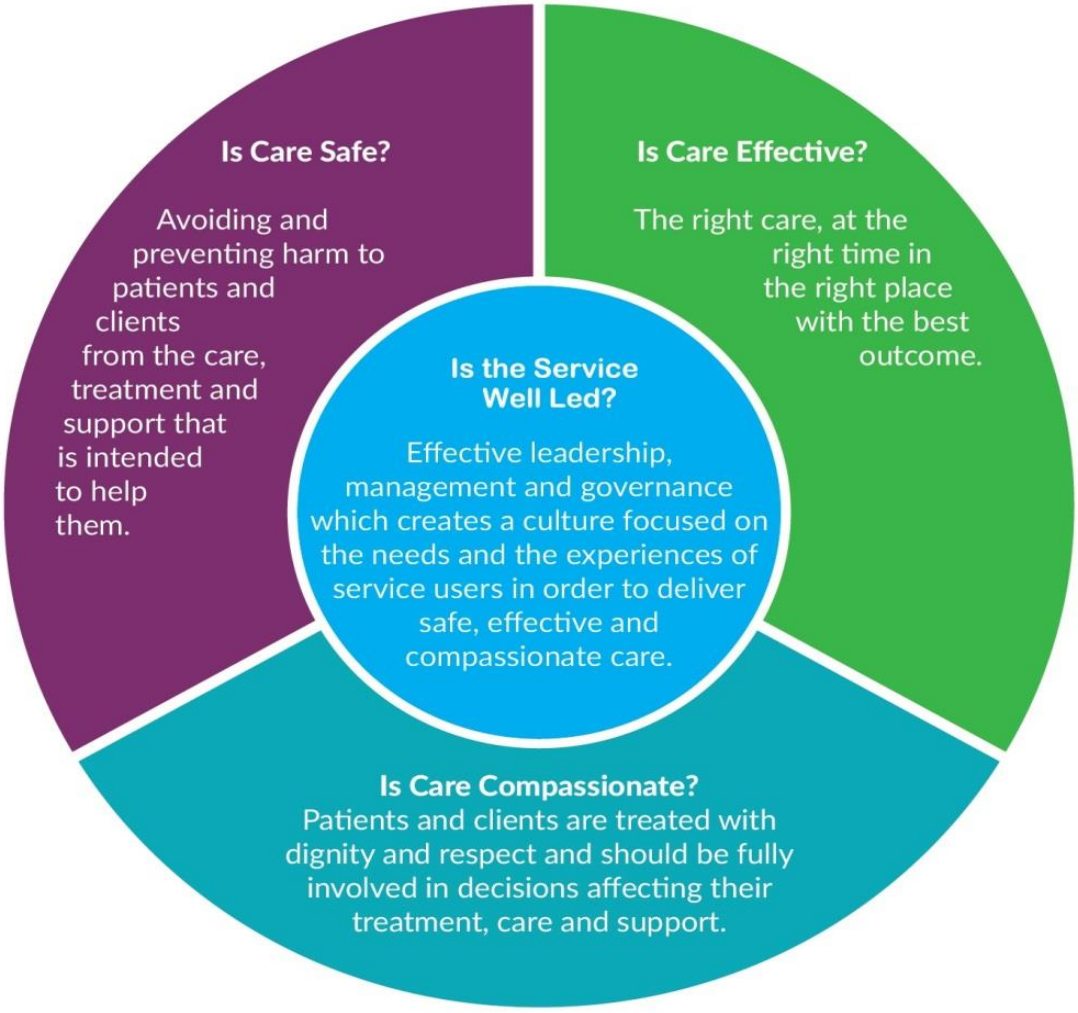
Unannounced Medicines Management Inspection Report
23 May 2018

Bohill Bungalows

Type of Service: Nursing Home
Address: 69 Cloyfin Road, Coleraine, BT52 2NY
Tel No: 028 7032 5180
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 18 beds that provides care for patients living with healthcare needs as detailed in Section 3.0.

This nursing home is situated on the same site as Bohill House nursing home and Strand House-Bohill Bungalows residential care home.

3.0 Service details

Organisation/Registered Provider: Amore (Watton) Limited **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager:** See box below
Person in charge at the time of inspection: Mrs Carina Blackford (Staff Nurse)	**Date manager registered:** Mrs Hazel McMullan (Acting Manager – no application required)
Categories of care: Nursing Homes (NH): LD – Learning disability LD(E) – Learning disability – over 65 years PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 18 including: NH-PH/PH(E) – a maximum of six patients to be accommodated in Bungalow 1 NH-LD/LD(E) – a maximum of 12 patients to be accommodated in Bungalows 2 and 3 a maximum of six patients accommodated in each bungalow

4.0 Inspection summary

An unannounced inspection took place on 23 May 2018 from 10.30 to 15.10.

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 governance arrangements for medicines, the administration of most medicines, record keeping, the management of controlled drugs and the storage of medicines.

An area for improvement was identified in relation to the management of liquid medicines.

Patients were noted to be relaxed and comfortable in their surroundings.

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 Mrs Carina Blackford, Nurse-in-Charge, 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 12 February 2018. 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, three registered nurses and the administrator.

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
- 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 12 February 2018

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 15 February 2017

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.

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 and epilepsy awareness was provided each year. Training in the management of enteral feeding is planned for later this month. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home.

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.

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.

Appropriate arrangements were in place for adding medicines to food, crushing medicines and administering medicines in disguised form. Care plans were maintained.

Discontinued or expired medicines were disposed of appropriately. On occasion, some currently prescribed medicines supplied in their original pack had been returned at the end of the medicine cycle. Medicines should not be unnecessarily disposed of. This was discussed and agreed it would be reviewed. 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. Medicine refrigerators and oxygen equipment were checked at regular intervals. A list of expiry dates for medicines was also maintained to alert staff of when to remove the medicine from stock as required.

Areas of good practice

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

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.

Most of the sample of medicines examined had been administered in accordance with the prescribers' instructions. Discrepancies in three liquid medicines were noted at the inspection. In relation to one medicine, the dosage of the medicine was not clear and the records of administration did not correlate with the separate administration record. This was followed up during the inspection. An area for improvement was identified.

There were arrangements in place to alert staff of when doses of weekly or monthly medicines were due.

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 sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. A care plan was maintained. Staff advised that some of the patients could tell staff if they were in pain; for those that were unable to, pain assessment tools was used as needed. Some of the staff advised that they had worked in the home for several years and were familiar with patients' verbal and non-verbal communication regarding pain.

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. Administration was recorded and 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. However, it was noted that one topical antibiotic preparation was being regularly refused; this was not recorded or referred to the prescriber. The staff advised that the prescriber would be contacted after the inspection. Due to the assurances provided that this ongoing refusal and any future refusals would be reported to the prescriber for review, an area for improvement was not identified.

Overall, the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate administration records for medicines which were not supplied in the 28 day blister packs, running stock balances for these medicines; and protocols for medicines prescribed on a "when required" basis, e.g. analgesics, laxatives and benzodiazepines.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the 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 in relation to the standard of record keeping, care planning and the administration of most medicines. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The management of liquid medicines should be reviewed in relation to record keeping and administration.

	Regulations	Standards
Total number of areas for improvement	0	1

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 was not observed at this inspection. Staff advised that the patients were given plenty of time to take medicines. 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.

We spoke with one patient who stated that they had no concerns regarding taking and receiving medicines and that they had settled into the home.

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 ten questionnaires which were left in the home to facilitate feedback from patients and their representatives, seven were returned within the specified time frame (two weeks). The responses indicated that they were very satisfied/satisfied with the care provided in the home. Three comments were also made:

"I like Strand House."
"I love living in Bohill Bungalows. I am glad I have met new friends."
"I like that Bohill gives me a chance to go on holidays."

Any comments in questionnaires returned after the two week time frame will be shared with the manager as required.

Areas of good practice

Staff listened to patients and relatives 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. Staff advised that there were arrangements in place to implement the collection of equality data within Bohill Bungalows.

Written policies and procedures for the management of medicines were in place. These were not examined. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents. 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. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date. A communication book was used to highlight changes, including medicines management to staff.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was discussed at team meetings and supervision. They advised there were good working relationships in the home with staff and the manager. They spoke positively about their work.

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

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 Mrs Carina Blackford, Nurse-in Charge, 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 **To be completed by:** 23 June 2018	The registered person shall review the management of liquid medicines. Ref: 6.5
	Response by registered person detailing the actions taken: All staff who did not attend Medication training in May 2018 to attend Boots medication training by end of August. Records of liquid medications to be rewritten clearly to match Administration records and MARR sheets All staff to measure liquids with syringes instead of medicine cups to lessen the chance of any discrepency

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