Unannounced Medicines Management Inspection Report
7 June 2017

Fishbourne House

Type of Service: Nursing Home
Address: 71 Spa Road, Ballynahinch, BT24 8PT
Tel No: 028 9756 1165
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 22 beds that provides care for patients living with age related needs, physical disabilities and terminal illness.

3.0 Service details

Organisation/Registered Provider: Mr William Brown & Mr James Alexander Speers	**Registered Manager:** Mrs Rosemary Lunn
Person in charge at the time of inspection: Mrs Grainne Massey (Registered Nurse)	**Date manager registered:** 18 November 2010
Categories of care: Nursing Care (NH) : 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 TI - terminally ill	**Number of registered places:** 22

4.0 Inspection summary

An unannounced inspection took place on 7 June 2017 from 10.00 to 12.50.

This inspection was underpinned by 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 during and 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 records for the administration of thickening agents, and care plans for the management of distressed reactions and pain.

One patient advised that he was “very happy in the home and that he felt safe as there was always someone about.”

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	2

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Grainne Massey, Registered Nurse, as part of the inspection process. Details were also discussed with Mrs Rosemary Lunn, Registered Manager, via telephone call on 13 June 2017. 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 18 July 2016.

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 incidents; it was ascertained that no incidents involving medicines had been 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 the inspector met with one patient, one care assistant and one registered nurse.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- controlled drug records
- medicine audits
- care plans
- medicines storage temperatures

There were no areas for improvement identified at the last medicines management inspection.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection and discussed with Mrs Rosemary Lunn, Registered Manager, via telephone call on 13 June 2017.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 18 July 2016

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 31 May 2016

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.

Training was discussed with the registered nurse and one care assistant. The registered nurse was relatively new to the home. She confirmed that she had received a thorough induction and had received training specific to medicines management. The care assistant confirmed that she had received training on the application of emollient preparations and administration of thickening agents. The registered manager confirmed that competency assessments were completed annually and that the impact of training was monitored through the home's auditing system. Two staff had attended training on the management of medicines via the enteral route within the last three months. This training was then disseminated to other registered nurses.

There were systems in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The registered nurse confirmed that this had been included in her training. There was evidence that 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 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. All staff had completed training via e-learning.

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

No controlled drugs subject to record keeping requirements were currently prescribed. 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.

Mostly satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin, insulin and medicines via the enteral route. The use of separate administration charts for insulin and fluid intake charts for documenting feeds, fluids and medicines was acknowledged. The fluid intake charts had been accurately maintained on most days, some improvements were discussed with the registered nurse who agreed to discuss the necessary improvements with the registered manager for immediate action.

The registered manager confirmed that discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

The majority of medicines were stored safely and securely and in accordance with the manufacturer's instructions. The medicines refrigerator was unlocked; the registered nurse advised that this was an oversight and would be addressed without delay. 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 medicine storage area was monitored daily; satisfactory temperatures were observed.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and 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.

The audits completed at this inspection indicated that medicines were being administered as prescribed. There were arrangements in place to alert staff of when doses of weekly medicines were due.

A small number of patients were prescribed a medicine for administration on a "when required" basis for the management of distressed reactions. The dosage directions were clearly recorded on the personal medication records. The medicines had not been used recently. 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; however, an area for improvement was identified, as care plans detailing when these medicines should be used were not in place.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff advised that most of the patients could verbalise their pain and a review of the care records evidenced that the management of pain was reviewed each month. However, an area for improvement was identified, as detailed care plans for the management of pain were not in place.

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. Care plans were in place. Records for the administration of thickening agents were not currently being maintained. 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.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the standard of maintenance of the personal medication records and the medication administration records and the records of administration of emollient preparations by care assistants.

Practices for the management of medicines were audited throughout the month by the staff and the registered manager. A sample of the audits was available for inspection.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas of good practice

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

Areas for improvement

The registered person should ensure that care plans for the management of distressed reactions are in place. The care plans should include details of any prescribed medicines.

The registered person should ensure that care plans for the management of pain are in place. The care plans should include details of any prescribed medicines.

The registered person should ensure that records for the administration of thickening agents are maintained.

	Regulations	Standards
Total number of areas for improvement	1	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.

We observed the administration of some of the morning medicines. They were observed to be administered in a caring manner.

We spoke with one patient who advised that they felt happy and safe in the home. They advised that they could call on the staff at any time for assistance. Medicine related issues were not discussed.

Fifteen questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Fourteen were returned within the timeframe, five from staff, five from relatives and four from patients. The responses were positive stating that they were “satisfied” or “very satisfied” with how medicines are managed in the home.

Patients were observed to be relaxed and comfortable. Staff were responding promptly to any requests. Staff were observed to be kind and courteous to the patients.

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.

Written policies and procedures for the management of medicines were in place. These were not reviewed at the inspection.

The registered manager confirmed that there were robust arrangements in place for the management of medication related incidents and that staff were aware that some medication incidents may need to be reported to the safeguarding lead.

A review of recent audit records indicated that satisfactory outcomes had been achieved. The registered manager advised that any issues would be discussed with staff for learning and improvement.

Following discussion with the registered nurse and one of the care assistants on duty, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

The registered nurse confirmed that any concerns in relation to medicines management could be raised with management.

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 Grainne Massey, Registered Nurse, and Mrs Rosemary Lunn, 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 QIP to RQIA office for assessment by the inspector.

Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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:** 9 July 2017	The registered person shall ensure that complete records for the administration of thickening agents are maintained. **Response by registered person detailing the actions taken:** RESIDENTS PRESCRIBED THICKENING AGENTS NOW HAVE AN INDIVIDUAL CHART TO RECORD THIS, IN ADDITION TO THE MEDICINE CARDEX WHERE IT IS ALSO RECORDED + THEIR CARE 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 18 **Stated:** First time **To be completed by:** 9 July 2017	The registered person shall ensure that care plans for the management of distressed reactions are in place; care plans should include details of any prescribed medicines. **Response by registered person detailing the actions taken:** CARE PLANS HAVE BEEN REVIEWED + UPDATED ACCORDINGLY.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 9 July 2017	The registered person shall ensure that detailed care plans for the management of pain are in place; care plans should include details of any prescribed medicines. **Response by registered person detailing the actions taken:** THIS IS NOW IN PLACE FOR ALL RESIDENTS + WILL BE REVIEWED MONTHLY

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews