Unannounced Medicines Management Inspection Report
21 September 2017

Lansdowne

Type of Service: Nursing Home
Address: 41 – 43 Somerton Road, Belfast, BT15 3LG
Tel No: 028 9037 0911
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 86 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 Healthcare **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** See box below
Person in charge at the time of inspection: Mrs Stella Law	**Date manager registered:** Mrs Stella Law – acting, no application required
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category DE – Dementia 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:** 86 including: a maximum of 17 patients in category NH-DE to be accommodated in the Dementia Unit

4.0 Inspection summary

An unannounced inspection took place on 21 September 2017 from 10.20 to 15.45.

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 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 the governance arrangements for medicines, the standard of maintenance of most medicine records, the management of controlled drugs and the storage of medicines.

An area which required improvement was identified in relation to personal medication records.

Patients were complimentary regarding the management of their medicines and 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	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Stella Law, 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 10 April 2017.

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.

During the inspection we met with two patients, three registered nurses and the manager.

A poster informing visitors to the home that an inspection was being conducted was displayed.

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
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 10 April 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 11 October 2016

Areas for improvement from the last medicines management inspection		
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 28 **Stated:** First time	The registered provider should ensure there are robust arrangements in place for the ordering and supply of medicines.	**Met**
	Action taken as confirmed during the inspection: There was evidence that satisfactory systems were in place to ensure that medicines were available for administration and also to identify and manage any low stock balances, or out of stock medicines.	
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time	The registered provider should ensure that where medicines are prescribed for use on a 'when required' basis for the management of distressed reactions, the reason for and the outcome of the administration are recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: Four patients' records were reviewed. We found that these medicines were rarely required to be administered on a 'when required' basis. However, it was acknowledged that a separate administration record to document the reason for and outcome of the administration was available.	

	For one patient whose dose of anxiolytic medicine had recently changed to a 'when required' dose and was being administered, this record was not in place. It was agreed that this would be commenced with immediate effect. Given these assurances this area for improvement has been assessed as met.	
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered provider should ensure that the audit process is further developed.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the auditing process had been developed and new procedures implemented.	

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 the management of medicines, pain, palliative care and swallowing difficulty had been provided in the last year. Staff and management also advised of the training regarding dementia which had been completed within the Dementia Care Framework.

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

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. They discussed in detail the difficulty in obtaining a supply of some medicines for one patient and the contact made between the prescriber and community pharmacy to minimise the delay. Antibiotics and newly prescribed medicines had been received into the home in a timely manner. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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

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.

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 e.g. insulin pen devices, eye preparations.

Whilst there were systems in place to monitor the temperature of medicine refrigerators and stock levels of oxygen equipment, it was found that the daily checks on the medicines refrigerator and weekly checks on oxygen cylinders had not always taken place as scheduled in the top floor treatment room. This was highlighted to staff and they provided assurances that they would be recommenced from the day of the inspection onwards.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessment, the management of medicines on admission, controlled drugs and the storage of prescriptions and 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.

With the exception of a few medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. The administration of those medicines which should be closely monitored were highlighted to staff and management. The manager agreed that these would be included in the audit process.

On occasion some medicines were required to be crushed prior to administration. This was clearly recorded on the medicine label and printed medication administration records.

There were robust arrangements in place to alert staff of when time critical medicines must be administered, including early morning medicines and also medicines which were prescribed at weekly intervals.

The management of distressed reactions, swallowing difficulty and pain was reviewed. Of the sample of records examined, the relevant information was recorded in the patient's medicine records and care files. From discussion with staff it was evident that they were knowledgeable regarding patients' individual needs.

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. They confirmed that most patients were generally compliant with their medicine regimes. In relation to one patient, they discussed the care plan regarding the management of the ongoing refusal of medicines.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of separate administration records for transdermal patches, high risk medicines, analgesics and antibiotics, and double signatures for the writing and updating of personal medication records and medication administration records. However, an area for improvement was identified regarding the completion of personal medication records, as a few of these were not accurate. This was discussed in relation to discontinued medicines, dosage directions and amended entries.

The management of medicines administered via an enteral feeding tube was reviewed. The patient's feeding regime and care plan were in place. The enteral feed was recorded on the personal medication record and records of each administration of fluids, including the total 24 hour fluid intake were maintained.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines, the standard of record keeping and care planning. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The completion of personal medication records should be reviewed to ensure that these are up to date and accurate at all times.

	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 to patients was completed in a caring manner and patients were given time to take their medicines.

Staff provided examples of when medicines were administered at a later or earlier time to facilitate the patients' preferences/needs. They 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.

The patients we met with spoke positively about their care and the management of their medicines. They were complimentary regarding staff and management. Comments included:

"The staff are very good."
"I get medicines if I am in pain."
"The food is good."

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.

We met with staff throughout the inspection. Comments included:

"We have a great team; it is one reason why I like this home."
"There is good support in this home."
"We are provided with lots of training."

Of the questionnaires which were left in the home to facilitate feedback from patients, staff and relatives, four were returned from patients, two from patient's representatives and two from staff. The majority of responses indicated that they were very satisfied/ satisfied with all aspects of the care in relation to the management of medicines. A few comments made regarding communication and provision of care were shared with the manager for her attention and follow up. They were also shared with the care inspector.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the staff listening to and taking account of the views of patients.

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 examined. Staff advised that they were familiar with them and were kept up to date of any changes.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how incidents were shared with them to inform learning and change of practice, if necessary. 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.

The auditing arrangement for medicines was reviewed. Audits were completed by the registered nurses and management. The audits included records of running stock balances for liquid medicines and analgesics, and a variety of other medicines which were not supplied in the 28 day blister packs. As part of the audit process, the community pharmacist visited the home on a periodic basic. Staff were reminded that the carried forward quantity should be routinely recorded for medicines transferring into a new medicine cycle. A review of the audit records indicated that largely satisfactory outcomes had been achieved. Staff advised of the procedures in place to manage any areas identified for improvement.

Following discussion with the manager and registered nurses, 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. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

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 Stella Law, 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 via 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 29 **Stated:** First time **To be completed by:** 22 October 2017	The registered person shall develop a system to ensure that personal medication records are kept up to date and accurate. Ref: 6.4
	Response by registered person detailing the actions taken: Robust systems has been implemented to ensure records are accurately recorded and updated, The personal medication records in the Kardex in question has been reviewed and re- written to match information in the Marr sheets. Records are reviewed, monitored on weekly and monthly basis by the Deputy Manager will record the review on the Company's Auditing systems already in place, ensuring information remains accurate. .

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

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