Unannounced Medicines Management Inspection Report
10 January 2017

Lisadian House

Type of Service: Nursing Home
Address: 87 Moira Road, Hillsborough, BT26 6DY
Tel no: 028 9268 9898
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Lisadian House took place on 10 January 2017 from 10.10 to 15.50.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. There were largely satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. However, two areas for improvement were identified in relation to the management of controlled drugs and the completion of medicine records. One requirement and one recommendation were made.

Is care effective?

Most areas of the management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Care plans pertaining to medicines management were in place. Two areas for improvement were identified in relation to the administration of medicines and the procedures to facilitate audit activity. Two recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. The patient consulted with, confirmed that they were administered their medicines appropriately. No requirements or recommendations were made.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. No requirements or recommendations were made.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Miss Esther Bell, Registered 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.

1.2 Actions/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced enforcement compliance inspection undertaken on 14 December 2016.

The purpose of this inspection was to assess the level of compliance achieved by the registered persons regarding the two failure to comply (FTC) notices issued on 13 September 2016:

- FTC Ref: FTC/NH/1264/2016-17/01
- FTC Ref: FTC/NH/1264/2016-17/02

Evidence was available to validate compliance with the FTC notices.

2.0 Service details

Registered organisation/registered person: Elim Trust Corporation Pastor Edwin Michael	**Registered manager:** Miss Esther Bell
Person in charge of the home at the time of inspection: Staff Nurse Julie Jeffers until 13.30 and Miss Esther Bell thereafter	**Date manager registered:** 14 January 2016
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 45

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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

We met with one patient, three registered nurses and the registered manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

Questionnaires were issued to staff, patients and relatives/patients' representatives, with a request that these be completed and returned within one week of the inspection.

A sample of 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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 December 2016

The most recent inspection of the home was an announced enforcement monitoring inspection. The completed QIP was returned and was approved by the care inspector. This QIP will be validated by the care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 10 December 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** Second time	It is recommended that the responsible individual should develop a system to monitor the stock balances and administration of Schedule 4 controlled drugs.	**Met**
	Action taken as confirmed during the inspection: The stock balances of Schedule 4 controlled drugs were checked every week and a record maintained.	
Recommendation 2 **Ref**: Standard 28 **Stated:** First time	Records of the outcomes of the auditing process for medicines management should be maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that records of the auditing activity had been maintained.	

Recommendation 3 **Ref**: Standard 18 **Stated:** First time	A detailed care plan should be maintained for any patient prescribed medicines for distressed reactions and the reason for and outcome of the administration should be recorded on each occasion.	**Met**
	Action taken as confirmed during the inspection: Of the sample of patients' records examined, a care plan was maintained. When administered the reason and outcome was recorded on most occasions.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for agency nurses, 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 was provided in the last year. The most recent training was in relation to diabetes.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and some handwritten entries on medication administration records were updated by two registered nurses. This is safe practice and should occur for all handwritten medicine entries. A recommendation was made.

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

There were records in place to record the receipt, administration and disposal of controlled drugs. 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. Examination of the controlled drug record book indicated that when part of an ampoule was not required, the quantity discarded was not always recorded or signed by two staff. Staff confirmed that the contents had been safely disposed.

The management of records pertaining to controlled drugs patches should be reviewed. Currently, loose sheets of paper are used to record the administration and the daily stock checks. The audit trails of some patches could not be concluded as there was no effective system for filing and the day of administration for weekly patches was unclear. For one patient it was found that one controlled drug patch had been administered two days late, and for another patient the audit trails on the administration of controlled drug patches could not be concluded. It was not clear from the records if the correct dose had been administered as prescribed. A requirement was made. The benefit of using a bound book to record the administration of patches was discussed. The registered manager clarified some of the information by email on 18 January 2017.

The arrangements for the management of high risk medicines e.g. warfarin and insulin were examined. Whilst it was acknowledged that separate administration records were in use, it was found that when an insulin dose was changed, the handwritten details on the administration records were not verified by two staff. A recommendation regarding handwritten entries was made above. In relation to warfarin, it was found that one incorrect dose had been administered. It was suggested that the days of the week should be recorded on the administration record to assist with administration. It was agreed that the registered manager would report this error to the prescriber and raise with staff.

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. A small number of expired medicines were removed from stock. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas for improvement

Two designated staff should be involved in the transcribing of medicines information; both staff should verify the accuracy. A recommendation was made.

The registered manager must review the management of controlled drugs to ensure that these are administered as prescribed; the day of administration of weekly patches is accurately recorded and the completed records are maintained in such a way that facilitates a clear audit trail. A requirement was made.

Number of requirements	1	**Number of recommendations**	1

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. A few discrepancies were highlighted and discussed with management. A small number of audit trails could not be concluded, mainly as the date of opening had not been recorded. A recommendation was made.

There was evidence that time critical medicines had been administered at the correct time.

Whilst there were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due, there were areas for improvement identified in the administration of controlled drug patches. See Section 4.3.

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 records examined. A few of these needed further detail. A care plan was maintained. 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 on most occasions. It was agreed that the personal medication records would be updated to include the full dosage instructions and all staff would be reminded to record the reason for and outcome of any administration.

With the exception of the controlled drug patches mentioned above, 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. Staff advised that most of the patients could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. The registered manager advised that a pain assessment was completed as part of the admission process.

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. Each 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. One patient's medicines were discussed regarding non-compliance and the management of their medicines. A care plan was in place.

The majority of medicine records were well maintained and facilitated the audit process. The times of administration on the medication administration records were recorded as meal times e.g. breakfast, lunch, dinner. The time of administration should be recorded. This was discussed in relation to minimum dosage intervals for medicines which were prescribed throughout the day. A recommendation was made.

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 registered manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns regarding medicines management.

Areas for improvement

The necessary arrangements should be made to ensure that the time of administration of medicines is clearly recorded. A recommendation was made.

The date of opening should be recorded on all medicines which are not contained within the monitored dosage system. A recommendation was made.

Number of requirements	0	**Number of recommendations**	2

4.5 Is care compassionate?

The administration of medicines to patients was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible.

The patient spoken to at the inspection advised that they had no concerns in relation to the management of their medicines, and their request for medicines prescribed on a 'when required' basis was adhered to. Comments were positive and the patient was very complimentary about the staff and the care in the home.

There was evidence of good relationships between staff and patients. Staff were observed to be friendly and courteous. They treated the patients with dignity.

As part of the inspection process, 26 questionnaires were issued to patients, relatives/patient's representatives and staff. Seven questionnaires were returned from one patient, three patients' relatives/representatives and three members of staff. The responses were recorded as 'very satisfied' or 'satisfied' with the management of medicines within the home. Two of the comments made were shared with the registered manager for her attention.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. Management advised that these were under review and development. The storage location of these was discussed and it was suggested that these should be moved to a place where staff could readily access them, especially in the registered manager's absence. 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 and provided details of the action taken and how learning was shared with staff.

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 registered manager and registered nurses, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff advised that there were effective communication systems in place. Verbal and written handovers were completed at the end of each shift. In addition, a daily head of department meeting was held, which included registered nurses, care staff and a representative from the laundry, kitchen and maintenance departments. In relation to medicines management, this meeting was used to inform staff of new admissions, discharges, medicines changes, dietary requirements, audit discrepancies and incidents.

Staff confirmed that any concerns in relation to medicines management were raised with management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Miss Esther Bell, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to pharmacists@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 10 February 2017	The registered provider must ensure that robust arrangements are in place for the management of controlled drugs.
	Response by registered provider detailing the actions taken: A new book has been commenced for the counting, administering and destruction of controlled drugs.
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 10 February 2017	The registered provider should review the management of medicine changes, to ensure that two staff are involved in the transcribing of medicines details onto medication administration records and insulin records.
	Response by registered provider detailing the actions taken: All staff have been reminded that 2 members of staff must transcribe medicine details. This will be evidenced through audits.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 10 February 2017	The registered provider should ensure that the time of administration of medicines is clearly recorded.
	Response by registered provider detailing the actions taken: Should a medicine which is prescribed as PRN be administered, this time will be documented on the MARS. The Pharmacy have agreed to write specific times on the MARS upon dispensing.
Recommendation 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 10 February 2017	The registered provider should make the necessary arrangements to ensure that the date of opening is recorded for all medicines which are not supplied in the monitored dosage system.
	Response by registered provider detailing the actions taken: Staff have been reminded to write the date of opening on the medicines and also on the sheet at the back of the MARS in order to facilitate auditing. This will be evidenced through the audit process.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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