Unannounced Medicines Management Inspection Report
8 November 2017

Lisburn Care Home

Type of Service: Nursing Home
Address: 119a Hillsborough Road, Lisburn, BT28 1JX
Telephone No: 028 9266 6763
Inspector: Frances Gault

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 38 beds that provides care for patients 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 below
Person in charge at the time of inspection: Ms Fiona Archer	**Date manager registered:** Ms Fiona Archer – acting, no application required
Categories of care: Nursing Homes 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:** 38 The home is also approved to provide care on a day basis to 1 person.

4.0 Inspection summary

An unannounced inspection took place on 8 November 2017 from 09.45 to 14.15.

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 training in relation to medicines, care records and the use of supplementary records.

An area which still required improvement was identified in relation to the accuracy of the personal medication records which did not always reflect the medicine administration records.

Patients and relatives spoken with spoke very positively about the care received 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*

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Ms Fiona Archer, Manager, and the registered nurse on duty 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 required to be taken following the most recent inspection on 11 October 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- 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 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.

During the inspection we met with two patients individually and several waiting for the hairdresser, five staff, and two relatives.

A total of 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

Areas for improvements 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 11 October 2017

The most recent inspection of the home was an unannounced care inspection.

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 28 June 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 29 **Stated:** First time	The registered provider should closely monitor the personal medication records and medicine administration records to ensure that they are legible, accurate and signed by the persons making the entries.	**Partially met**
	Action taken as confirmed during the inspection: Those records reviewed had been signed by two registered nurses. The evidence seen indicated that there was not complete accuracy between the information recorded on the personal medication records and the medicines administration records. Details of medicines which had been discontinued were still included on the medicine administration records. The manager advised that she was aware of the problem and had discussed it with the community pharmacist in order to get it addressed. This area for improvement is stated for the second time	

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. Staff were up to date in their training in relation to the use of the monitored dosage system, care of medicines (foundation) and care of medicines (advanced).

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 and to ensure that patients had a continuous supply of their medicines. When medicines were discontinued the details were not always manually updated on the medicine administration records, with the result that there were discrepancies between the information on the personal medication records and the administration records. This area for improvement against the standards was stated for the second time (see section 6.2). Personal medication records and handwritten entries on medication administration 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.

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

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. warfarin and insulin. The use of separate administration charts was acknowledged.

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. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas of good practice

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

Areas for improvement

No new 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 sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, specific 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. A care plan was maintained. None of these medicines had required to be administered recently.

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 tool was used as needed. A care plan was maintained. Staff also 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. The fluid balance charts in use evidenced the consistency to be used. Care assistants were knowledgeable about their role in this practice.

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.

The completion of the majority of the medicine records facilitated the audit process. Areas of good practice were acknowledged. They included the use of supplementary records for the administration of some medicines and the highlighting of records where patients shared a common name.

Practices for the management of medicines were audited throughout the month by the staff and management. The outcomes were used to develop an action plan to address any discrepancies and this was shared with staff. Running stock balances were maintained for several solid dosage medicines and liquids. The accuracy of these balances was discussed with the manager who was aware that improvement in their accuracy was necessary. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the health of the patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records, audits and reviews, communication between patients, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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, patients were given time to take their medicines and medicines were administered as discreetly as possible. The nurses enquired of each patient whether they required pain relief.

There was a calm and organised atmosphere in the dining room during the serving of breakfast. Throughout the inspection care staff were heard greeting patients and asking how they were that day.

Several patients were awaiting their weekly hair appointment. They engaged in general conversation about their experience of the home. All were positive in their comments.

One patient advised that the welcome received during a trial period in the home had made them decide to live there permanently.

Two relatives on a visit said the place was homely and that they “can’t praise staff enough.”

Ten questionnaires were left in the home to facilitate feedback from patients, and their representatives. One was returned within the time frame from a patient who advised that they were very satisfied with all aspects of the care, while five were returned from relatives who advised that they were satisfied/very satisfied with all aspects of the care.

Patient comments:

“The happy atmosphere of the home is conducive to a feeling of well being for those of us who are able to appreciate it”.

Relatives comments included:

“We are very happy with the care she receives; she has always been treated with dignity and respect. It is very clear that the staff are caring and dedicated.”

“I visit my mum frequently in Lisburn Care Home and I think she is well looked after by all members of staff”.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, staff were listening to and valuing patients and taking 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 examined during the inspection.

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 lead and safeguarding team.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Following the last internal audit in October 2017, an action plan had been developed which was shared with staff. The manager advised that the outcomes would be examined as part of the next audit.

Following discussion with the manager, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. One recently appointed Care Home Assistant Practitioner was able to explain their role and how it differed to that of the other care staff and nurses.

The area for improvement against the standards made at the last medicines management inspection had not been fully addressed. To ensure that this is fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of medicine incidents, quality improvement and maintaining good working relationships.

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 Ms Fiona Archer, Manager, and the registered nurse on duty 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 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:** Second time **To be completed by:** 30 November 2017	The registered provider should closely monitor the personal medication records and medicine administration records to ensure that they are legible, accurate and signed by the persons making the entries. Ref: 6.2
	Response by registered person detailing the actions taken: Discussions have been held with each individual FSHC Registered Nurse regarding handwriting , the need that all medication transcription are completed in print, are always legible, and reflect the presciption. Handwritten medication records are being re written to ensure that these documets are legible and accurate. Home Manager continues to monitor compliance for eligibility and facilitates the legibility and accuracy of the documents.Monitoring of medications is undertaken on a daily, weekly and monthly basis through the Quality of Life IT systems, in addition to routine reporting processes..

The Regulation and Quality Improvement Authority

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