Unannounced Medicines Management Inspection Report
28 June 2016

Lisburn Care Home

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

1.0 Summary

An unannounced inspection of Lisburn Care Home took place on 28 June 2016 from 09:00 to 13:50.

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 systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas of improvement identified.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. One area of improvement was identified in relation to record keeping and a recommendation was 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. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

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. There were no areas of improvement identified.

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	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Karen Moriarty, Registered Manager and Mrs Simona Birsanu, Deputy 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

There were no further actions required to be taken following the most recent inspection on 7 January 2016.

2.0 Service details

Registered organisation/registered provider: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Mrs Karen Moriarty
Person in charge of the home at the time of inspection: Mrs Simona Birsanu, Deputy Manager who was later joined by Mrs Karen Moriarty, Registered Manager	**Date manager registered:** 01 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 38

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.

It was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with five patients, one care staff, two 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.

A sample of the following records was examined:

- 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 care inspection dated 7 January 2016

The most recent inspection of the home was an unannounced care inspection. The inspection resulted in no requirements or recommendations being made.

The care inspector for the home advised that RQIA had received information in relation to the early rising of some patients. While a response had been requested from the home it was agreed that the issue would be raised during the medicines management inspection.

At the commencement of the inspection most patients were enjoying their breakfast in the dining room. The deputy manager advised that three or four patients had been up when she arrived in the home about 07:00. The registered manager also confirmed that she and the regional manager had undertaken an early morning visit earlier in the week and five patients were up, one of whom had an early hospital appointment. The registered manager advised that early rising was the normal habit of these patients and the practice was documented in their care plans.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 2 May 2013

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref:** Regulation 13(4) **Stated:** Once	The registered manager must ensure that medicines are discarded once their expiry date has been reached.	**Met**
	Action taken as confirmed during the inspection: The evidence seen during the inspection indicated that medicines were discarded once their expiry date was reached.	

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 registered nurses and care staff who had been delegated medicine related tasks. The registered manager advised that the community pharmacist offered nurses the opportunity to visit the pharmacy as part of their induction to see the process followed when the prescriptions are sent for dispensing. This gave them a greater understanding of the role of the community pharmacist and the importance of working closely to ensure patient safety was maintained.

The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. The registered manager was able to evidence through the computer records that all training in relation to medicines was up to date. The registered manager advised of the close working relationship with the trust who supported any training needs identified e.g. swallowing awareness for care staff.

The home facilitates student nurse placements and this is welcomed as the registered manager said it helped to maintain standards within the home.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The deputy manager advised that she undertook drug rounds throughout the home and this enabled her to quickly identify any concerns. The registered manager said that the community pharmacist had been complimentary about the staff in relation to the systems in place for the management of medicines which ensured positive outcomes for the patients as they had a continuous supply of their prescribed medicines.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated and usually signed by two registered nurses. This safe practice was acknowledged.

The procedures in place to ensure the safe management of medicines during a patient's admission to the home were evidenced to be robust.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged.

The management of swallowing difficulty was examined. The care assistant spoken with was knowledgeable regarding her role in the administration of thickening agents and the recording system in place for completion. A care plan was in place for a patient who, on occasion, had a poor swallow. This included advice from the prescriber as to how medicines were to be administered. The evidence seen indicated that this is kept under review.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. The storage area had recently been repainted and the deputy manager advised of the changes that had already taken place and were planned to streamline the storage of medicines. 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 for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

The vast majority of medicines examined had been administered in accordance with the prescriber's instructions. The administration record for some analgesic tablets was open to misinterpretation making the audit outcomes inaccurate as both the quantity administered and the signatures of the nurses were documented in limited space.

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.

Medicine records were usually well maintained and facilitated the audit process. However, a few anomalies were noted where staff had omitted to countersign the handwritten entry on the medicine administration records, and on occasion the entry on the personal medication record did not correspond with that on the medicine administration records. On occasions the entries on the medicine administration records were difficult to interpret (see above). A recommendation was made.

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 their 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. One care plan evidenced the steps in place to manage the pain being experienced by one patient. This had included seeking advice from the local trust. The daily evaluations then indicated that the patient was pain free.

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.

Practices for the management of medicines were audited throughout the month by the staff and management. The monthly audit had been completed the previous day and an action list drawn up to deal with the minor discrepancies identified. An external quarterly audit is undertaken by the community pharmacist.

Following the evidence seen and discussion with the registered manager and staff, it was obvious that when applicable, other healthcare professionals were contacted in response to the health care needs of the patients.

Areas for improvement

The personal medication records and medicine administration record should be closely monitored to ensure that they are legible, accurate and signed by the persons making the entries. A recommendation was made.

Number of requirements	0	Number of recommendations	1

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. None of the current patients look after their own medication.

At the start of the inspection patients were finishing their breakfast. They expressed their satisfaction with the staff and their care. Their comments included:

“I never get a headache”
“I get a tablet every morning”
“the porridge is very good”
“we have plenty of chat and laughs”
“staff are very 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.

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. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff. The registered manager advised that all medicine policies and procedures and the audit records were located in the treatment room so that they were readily accessible to staff.

There were robust arrangements in place for the management of medicine related incidents. No medicine incidents have been reported to RQIA in recent years.

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 (see section 4.4).

Following discussion with the registered manager, registered nurses and care staff, 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. The registered manager advised that staff were proactive when identifying or raising any concerns.

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 this QIP were discussed with Mrs Karen Moriarty, 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 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 taken by the Registered Provider

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

Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 31 July 2016	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. **Response by registered provider detailing the actions taken:** The manager and deputy manager will continue to monitor and audit personal medication records and MAR to ensure legible,accurate and signed accordingly. The nurses have been asked to contact the GP to review the PRN analgesia prescriptions as the way it has been written by the GP makes it difficult for nurse to sign document dose given and code in the limited space available. The deputy manager and the nuses in the home are aware of the results of the inspection and the above recommendation and action to be taken.

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

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