Unannounced Medicines Management Inspection Report
25 June 2018

Pond Park Care Home

Type of Service: Nursing Home
Address: 2 Derriaghy Road, Lisburn, BT28 3SF
Tel No: 028 9267 2911
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 58 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 (Bamford) Ltd **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** See box below
Person in charge at the time of inspection: Mr Tony Hart	**Date manager registered:** Mr Tony Hart (Acting – no application required)
Categories of care: Nursing Homes (NH): DE – Dementia 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:** 58 including: a maximum of 11 patients in category NH-DE accommodated in the Wallace Suite there shall be a maximum of four named residents receiving residential care in category RC-I

4.0 Inspection summary

An unannounced inspection took place on 25 June 2018 from 09.55 to 16.30.

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, training, general medicines administration, care planning, medicines storage and the management of controlled drugs.

One area for improvement was identified in relation to the completion of medicine records.

Patients said they were happy in the home and spoke positively about the management of their medicines and the care provided by staff. We noted the warm and welcoming atmosphere 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 Mr Tony Hart, Manager and Mr Daniel Oliveria, Manager, Four Seasons Health Care, 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 25 April 2018. 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 medicine related incidents reported to RQIA since the last medicines management inspection.

During the inspection we met with three patients, one patient's relative, three registered nurses, two care staff, the manager and another member of the management team from Four Seasons Health Care.

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

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

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

We provided the manager with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We also left 'Have we missed you' cards in the foyer of the home to inform patients and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of service provision.

We asked the manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

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 25 April 2018

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 14 June 2017

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 29

Stated: First time</td><td>The registered person shall ensure that all handwritten entries on medicine records/care plans are legible and can be audited.

Ref: 6.5</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The sample of care plans and medicines records reviewed at the inspection were legible and auditable.</td></tr>
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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 at least annually. There were systems in place to ensure that all staff receive update training in relation to medicines management. Refresher training in the management of swallowing difficulty and dementia was provided in the last year and the most recent training was in relation to Parkinson's.

There were satisfactory procedures in place to ensure the safe management of medicines during a patient's admission to the home. Written confirmation of the medicine dosage regimes was obtained prior to or at admission, and two staff were involved in writing the personal medication record, which is safe practice.

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.

The management of medicine changes was reviewed. Personal medication records and handwritten entries on medication administration records were usually updated by two registered nurses. However, for one patient, it was noted that whilst the discontinued medicines had been clearly recorded, two new medicines had not been added to the personal medication record; they had been administered as prescribed. This was addressed at the inspection. See also Section 6.5.

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.

The management of high risk medicines was reviewed e.g. warfarin and insulin. Warfarin dosage regimes were received by telephone and also confirmed in writing. Two staff had signed the transcribing on most but not all occasions. This was further discussed and it was agreed that it would be raised with staff. The use of separate administration charts was acknowledged for warfarin and insulin.

Appropriate arrangements were in place for administering medicines in disguised form. A care plan was maintained.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

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 in relation to staff training, competency assessment, the storage of medicines and the management of 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.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. A few discrepancies were noted and discussed. Management assured that these medicines would be closely monitored within the audit process.

There was evidence that time critical medicines had been administered at the correct time. There were robust arrangements in place to alert staff of when doses of medicines prescribed at specific intervals were due, i.e. mid-weekly, weekly, three monthly or six monthly; the date of the next dose was clearly recorded on the administration records.

The management of pain, distressed reactions and swallowing difficulty were reviewed. The relevant medicine records and care plans were maintained.

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.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate administration records for transdermal medicines and protocols for "when required" medicines, such as analgesics, benzodiazepine, antiemetics and laxatives. However, there was some non-correlation between the personal medication records and corresponding medication administration records. See also Section 6.4. Personal medication records and the corresponding medication administration records must be accurate. An area for improvement was identified.

Practices for the management of medicines were audited throughout the month. The audit process included the recording of running stock balances for some medicines which were not supplied in the 28 day blister pack system. This readily facilitates the audit process.

Following discussion with management and staff and a review of a sample of care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs. They provided examples of when this had occurred recently in relation to pain management, swallowing difficulty and skincare.

Areas of good practice

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

Areas for improvement

A robust system should be developed and implemented to ensure that personal medication records and medication administration records are fully and accurately maintained.

	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 not observed at the inspection. Following discussion with the staff they confirmed how medicines were administered and advised that patients were encouraged and given time to take their medicines. The staff were knowledgeable about the patient's medicines and their medicine regimes.

Throughout the inspection, it was found that there were good relationships between the staff, patients and the patients' representatives. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear from discussion and observation of staff, that they were familiar with the patients' likes and dislikes.

We met with three patients, who expressed their satisfaction with the care, the staff and the manager. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were responded to and stated that they had no concerns. Comments included:

"The staff are very good; they're all very good."
"I am looked after very well."
"The food is very good in here. I do get a choice."
"The staff are very good to you. I have no complaints."
"I'm happy here. I've settled well."

Some patients were noted to be outside enjoying the weather.

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 also met with one relative who spoke very positively about the care provided, the food and her relative's experience in the home.

Of the questionnaires which were left in the home to receive feedback from patients and their representatives, none were returned within the specified time frame (two weeks). Any comments from patients and their representatives in questionnaires received after the return date will be shared with the manager for their information and action as required.

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.

The management arrangements for the home were discussed. The new interim manager had commenced his post in the last week and advised of his role in the home and the support in place from Four Seasons Health Care.

The inspector discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. We were advised that there were arrangements in place to implement the collection of equality data within Pond Park Care Home.

Written policies and procedures for the management of medicines were in place and were readily available for staff reference. Staff confirmed that there were systems to keep them updated of any changes.

The governance arrangements for medicines management were reviewed. Management advised of the daily, weekly and monthly audits which take place and how areas for improvement were identified and followed up. This was usually through the development of action plans and staff supervision.

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 procedures in place to ensure that all staff were made aware of incidents and to prevent recurrence. 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.

Following discussion with the registered manager and 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. They advised that any resultant action was communicated with staff individually, at team meetings or supervision.

The staff we met with spoke positively about the home, how they enjoyed their work, the team work and the good working relationships in the home and with other healthcare professionals.

We were informed that there were effective communication systems in the home to ensure that all staff were kept up to date about the patients.

No online questionnaires were completed by staff within the specified time frame (two weeks).

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 Mr Tony Hart, Manager and Mr Daniel Oliveria, 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 via the 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	The registered person shall review the system to ensure that personal medication records and medication administration records are accurate. Ref: 6.5
To be completed by: 25 July 2018	**Response by registered person detailing the actions taken:** Closely monitored through the Four Seasons Health Care Audit process. Boots training organised for new staff in relation to Personal Medication Records. Registered nurses informed of PMR / MAR correlation issues.

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

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