Unannounced Medicines Management Inspection Report
14 June 2017

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 adults living with old age, dementia, physical disability or terminal illness.

3.0 Service details

Registered organisation/registered person: Four Seasons (Bamford) Ltd **Responsible Individual:** Dr Maureen Claire Royston	**Registered manager:** Mrs Suzanne Scott
Person in charge of the home at the time of inspection: Mrs Suzanne Scott	**Date manager registered:** 19 May 2014
Categories of care: <u>Nursing Home (NH)</u> 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 <u>Residential Care (RC)</u> I – Old age not falling within any other category	**Number of registered places:** 58 comprising: - a maximum of 11 patients in category NH-DE accommodated in the Wallace Suite - of the residents in category RC-I, a maximum of 4 residents shall be accommodated in single occupancy bedrooms 21, 22, 24 and 25 and a maximum of 3 residents in the Pond Park Unit

4.0 Inspection summary

An unannounced inspection took place on 14 June 2017 from 10.00 to 16.35.

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.

The term ‘patients’ is used to describe those living in Pond Park Care Home which provides both nursing and residential care.

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 administration of medicines, the management of controlled drugs and storage of medicines.

An area requiring improvement was identified in relation to the legibility of one care plan and completion of some medicine records.

Patients were complimentary regarding their care and management of medicines.

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 Ms Suzanne Scott, 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.

4.2 Action/enforcement taken following the most recent care inspection

The most recent care inspection was completed on 3 April 2017.

Following this inspection, a concerns meeting was held in the Regulation and Quality Improvement Authority (RQIA) Belfast Office on 7 April 2017 with representatives from Four Seasons (Bamford) Ltd, to discuss the areas for improvement identified. At this meeting, a full account of the actions taken was provided; RQIA decided to give the management of the home a period of time to address the concerns and drive the necessary improvement.

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

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

During the inspection the inspector met with three patients, two relatives, two care staff, two registered nurses, the deputy manager and the registered manager.

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
- policies and procedures
- 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 3 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 13 September 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 12(1) **Stated:** First time	The registered provider must make the necessary arrangements to ensure robust arrangements are in place to manage medicine changes.	**Met**
	Action taken as confirmed during the inspection: A sample of prescribed medicine changes were reviewed at the inspection. Robust arrangements were in place.	

Area for improvement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that personal medication records are fully and accurately maintained at all times.	**Met**
	Action taken as confirmed during the inspection: Improvement in the standard of maintenance of personal medication records was evidenced at the inspection. The sample examined had been maintained in the required manner.	
Area for improvement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must ensure that a record of the administration or non-administration of a medicine is maintained on every occasion.	**Met**
	Action taken as confirmed during the inspection: Most of the medication administration records examined at the inspection were well maintained and indicated that medicines had been administered as prescribed.	
Area for improvement 4 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must review the management of medicines administered via an enteral feeding tube to ensure that the fluid intake chart is fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: Improvement in the completion of enteral feeding fluid intake charts was evidenced at the inspection. These clearly indicated that the administration of medicines was accompanied by flushes of water and all other flushes were recorded. Some but not all charts included the total 24 hour fluid intake. The registered manager advised that this should be recorded and would be addressed with staff.	

Area for improvement 5 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must develop a robust system to audit all aspects of medicines management and ensure that any areas for improvement are followed up.	**Met**
	Action taken as confirmed during the inspection: A variety of auditing systems for medicines management were in place. They included daily and weekly audits of medicines which were not supplied in 28 day blister packs. A list of the types of audits to be completed each week was displayed. Any areas identified for improvement were reported to management and raised at team meetings and/or staff supervision.	
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 18 **Stated:** First time	The registered provider should review the management of distressed reactions to ensure that this is recorded in a care plan and the reason and outcome of each administration are recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the management of distressed reactions was recorded in a care plan. The daily notes usually included the reason for and outcome of any administration of medicines.	
Area for improvement 2 **Ref**: Standard 41 **Stated:** First time	The registered provider should make the necessary arrangements to ensure that staff are aware of their roles and responsibilities in relation to medicines management.	**Met**
	Action taken as confirmed during the inspection: Following discussion with staff, it was evident that they were aware of the roles and responsibilities and to report medicine related issues to management.	

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 dysphagia, external preparations, syringe drivers and medicines management was provided in the last year. The registered manager was reminded that practical training sessions e.g. syringe drivers, should be also be recorded. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Further safeguarding training is planned.

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. One eye preparation had been out of stock; this had been ordered and was due for delivery on the evening of the inspection.

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 for the safe management of medicines during a patient's admission to the home and discharge from the home and for the management of medicine changes.

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. Care plans were maintained.

Largely satisfactory arrangements were in place for administering medicines in disguised form. A care plan was in place; however, further detail should be recorded on one care plan and this was discussed. The deputy manager provided assurances that this would be addressed.

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 each day.

Areas of good practice

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

Whilst most of the audits completed on a sample of medicines indicated they had been administered as prescribed, a few audit trails could not be concluded due to the standard of record keeping. An area for improvement regarding record keeping was made below.

There was evidence that time critical medicines had been administered at the correct time. Arrangements were in place to alert staff of when doses of weekly patches or three monthly injectable medicines were due. However, for one injectable medicine, it could not be confirmed if the dose had been administered. This was being addressed with staff during the inspection.

Epilepsy management was detailed in the patient's care plan.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, a care plan was maintained. The 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. The reason for and the outcome of administration were usually recorded.

The management of pain was examined. Care plans and pain assessment tools were maintained. Following discussion with staff, it was clear that they were aware of the patients' pain needs and offered pain relief on a regular basis. They advised that most of the patients could verbalise any pain. The majority of records examined indicated that pain controlling medicines had been administered as prescribed; however, it was difficult to audit some records due to the record keeping. The registered manager advised that she would implement a running stock balance for analgesics.

For those patients with swallowing difficulty and who were a 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. Staff provided examples of when medicine formulations were changed to aid the patient's swallowing and compliance. It was noted that one patient refused a medicine which was prescribed on a weekly basis. This was highlighted at the inspection and was being addressed by staff.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the use of separate administration charts for high risk medicines and transdermal patches, protocols for 'when required' medicines and double signatures on personal medication records and medication administration records for new medicines/medicine changes. However, an area for improvement was identified. The legibility of records was discussed in relation to one care plan and signatures on the medicine administration records. It was difficult to read the handwritten detail in the care plan and it was not clear if the staff initial on the medicine administration records was to denote administration or non-administration of some medicines. Records must be legible. Staff were reminded that all codes for non-administration should be circled and records must be easily read.

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

Areas of good practice

There were examples of good practice in relation to the standard of record keeping for most medicine records, care planning, staff knowledge and the administration of medicines.

Areas for improvement

Records should be reviewed to ensure that entries are legible and can be audited.

	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, patients were given time to take their medicines and medicines were administered as discreetly as possible.

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 that the staff were familiar with the patients' needs, their likes and dislikes.

Patients advised that they were content with the management of their medicines and the care provided in the home. They were complimentary regarding staff and management. Comments included:

"It is good here"
"I have a nice bedroom and bed"
"I enjoyed my lunch"
"I don't have pain"

One visitor and one relative came to speak to us. Both spoke positively about the staff, management and the care delivery in the home. Comments included:

"She is looked after very well"
"I would recommend this home"
"This home is spacious and clean"
"I want to give you complimentary feedback about this home"

We also spoke with a number of staff; their comments included:

"This is a good unit, there's great support and from relatives."
"I can't complain."
"I love my job, I love the patients."
"I am happy in this home."

A few of the staff advised that they would like more permanent staff. This was discussed with management at the inspection and we were advised of the ongoing recruitment processes.

Of the questionnaires that had been issued, none had been returned to RQIA at the time of sending this report.

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.

Written policies and procedures for the management of medicines were available in each treatment room. 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. 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.

The auditing procedures for medicines management had been reviewed. Regular audits were completed. All areas of medicines management were included. In addition, an audit was undertaken by a representative from the community pharmacy. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

As part of the governance processes in the home, staff advised that senior staff/management walked around each unit every morning and used the outcomes of the handover report to ensure any issues were addressed. This walk also enabled the administration of medicines to be observed.

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. 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.

The areas for improvement identified at the last medicines management inspection had been addressed. The progress made was acknowledged.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, 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 Mrs Suzanne Scott, Registered 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:** 14 July 2017	The registered person shall ensure that all handwritten entries on medicine records/care plans are legible and can be audited. Ref: 6.5
	Response by registered person detailing the actions taken: This has been addressed with the identifed staff member whose handwritten entries on the medicine records and care plans were difficult to read. The standard of handwriting will be monitored through the internal auditing process and appropriate action taken if required.

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

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews