The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
5 January 2018

Redburn Clinic

Type of Service: Nursing Home
Address: 89 Belfast Road, Ballynahinch, BT24 8EB
Tel No: 028 9756 3554
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 27 beds that provides care for patients as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Spa Nursing Homes Ltd **Responsible Individual:** Mr Christopher Philip Arnold	**Registered Manager:** See comment below
Person in charge at the time of inspection: Mrs Linda Kelly	**Date manager registered:** Mrs Linda Kelly – 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:** 27 There shall be a maximum of one named resident receiving residential care in the category RC - I

4.0 Inspection summary

An unannounced inspection took place on 8 January 2018 from 10.00 to 13.25.

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 medicine governance, medicine administration and training.

An area requiring improvement was identified in relation to the maintenance of personal medication records.

Patients spoke positively about living in the home and the care they received.

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 Mrs Linda Kelly, 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 inspection was an enforcement compliance inspection on 20 December 2017. This inspection validated compliance with the matters in the failure to comply notice issued on 24 October 2017.

No further actions were required to be taken following 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 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 three patients individually and several sitting in the lounge, two staff and one patient's visitors/representatives.

Ten questionnaires were provided for distribution to patients, their representatives and visiting professionals 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
- policies and procedures
- 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 20 December 2017

The most recent inspection of the home was an unannounced enforcement compliance inspection. The inspection focused solely on the validation of compliance with the matters detailed in the failure to comply notice issued on 24 October 2017. The home was assessed as compliant with the matters in the failure to comply notice.

The areas for improvement from the previous care inspection on 16 and 17 October 2017 as detailed in the QIP from that inspection 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 28 July 2016

<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 26

Stated: Second time</td><td>It is recommended that the management of medicines prescribed on a “when required” basis for distressed reactions is reviewed and revised.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The management of medicines prescribed on a “when required” basis for distressed reactions had been reviewed.

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,</td></tr>
</table>

	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. A care plan was maintained.	
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that the record of disposed medicines is signed by the nurse disposing of the medicine and a witness who is present for the disposal.	**Met**
	Action taken as confirmed during the inspection: The record book was signed by two nurses.	

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. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines was provided in the last year. The most recent training was in relation to behavioural support management. The community pharmacist was also due to do an annual update for registered nurses.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. 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. However, the entries on the personal medication records were not always updated by two registered nurses (see 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.

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.

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. The use of separate administration charts was acknowledged.

Staff advised that discontinued or expired medicines were sent to the local pharmacist for placing in yellow bins prior to being returned to the home for collection by a waste disposal company. They were advised that these medicines should be placed directly in yellow bins in the home and then collected by the waste disposal company. The manager agreed to review the practice. Further guidance is available on the RQIA website. 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 were checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff, training, supervision and appraisal, adult safeguarding, the storage of prescriptions and medicines.

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.

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 or three monthly medicines were due.

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 is 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.

The majority of medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the use of additional administration records for the administration of antibiotics and prescribed patches. The personal medication records required reviewed. When implemented these were signed by two registered nurses. It was noted that this was not routine practice when new medicines were prescribed. It was also noted that when medicines were discontinued, the entries were not always dated and signed. The manager advised that this had been picked up at a recent audit but had not yet been addressed due to the holiday period. An area for improvement was identified.

Practices for the management of medicines were audited throughout the month by the staff and management.

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

An area for improvement was identified in relation to the completion of the personal medication records.

	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. During the inspection the nurse spent time encouraging a patient to take her medicines and ensuring that she was also having sufficient to drink. Medicines were administered as discreetly as possible.

Ten questionnaires were left in the home to facilitate feedback from patients, staff and relatives. None were returned within the time frame.

Patient comments received during the inspection:

“(the nurse) is very kind”
“Staff give me lots of encouragement”

"Staff very good"

Relatives comments included:
"(the nurse) is very good"
"They are well looked after"
"The staff are very caring"

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. All patients were clothed appropriately for the environment.

Areas of good practice

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

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

The recommendations made at the last medicines management inspection had been addressed.

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 Mrs Linda Kelly, 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 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:** 28 February 2018	The registered person shall ensure that the personal medication records are completed accurately and entries signed by two registered nurses. Ref: 6.5
	Response by registered person detailing the actions taken: Staff meeting was held and all nursing staff reminded of the importance of having two nurses check and sign all medication entries on administration sheets. Nurse Manager will do spot checks to ensure this is adhered to.

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

Assurance, Challenge and Improvement in Health and Social Care