Unannounced Medicines Management Inspection Report
30 October 2017

Cullion House

Type of Service: Nursing Home
Address: 20 Wheatfield Gardens, Belfast, BT14 7HU
Tel No: 028 9039 1555
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 which is registered to provide nursing care for up to 22 persons.

3.0 Service details

Organisation/Registered Provider: Donnelly Care Group Ltd **Responsible Individual:** Mr Cathal John Donnelly	**Registered Manager:** Mrs Dora Syatwinda
Person in charge at the time of inspection: Mrs Dora Syatwinda	**Date manager registered:** 27 July 2017
Categories of care: Nursing Homes (NH) LD – Learning disability LD(E) – Learning disability – over 65 years Associated physical disablement	**Number of registered places:** 22

4.0 Inspection summary

An unannounced inspection took place on 20 October 2017 from 11:30 to 15:25.

This was the first medicines management inspection to the home since it was re-registered in June 2017, following a change of ownership and registration of a new provider. A new manager had been appointed to the home in July 2017.

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 for medicines, the standard of maintenance of medicine records, staff training and competency assessment and the storage of medicines.

An area requiring improvement was identified in relation to pain management.

Patients were noted to be relaxed and comfortable in their surroundings and interactions with staff.

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 Dora Syatwinda, 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

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 23 August 2017. 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

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

During the inspection we met with one patient, two relatives, two staff and the registered manager.

A total of 10 questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to complete 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
- medicine audits
- 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 23 August 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 19 December 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 13(4) **Stated:** Second time	The registered person must ensure that where care staff are responsible for the administration of external preparations and thickening agents, accurate records of administration are maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the record keeping for external preparations and thickening agents had been reviewed and improvement was noted. New records had been implemented and were included in the audit process.	

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. A sample of records was provided. A programme of training was in place. In the last year, training in the management of medicines, safeguarding, enteral feeding, swallowing difficulty and dementia had been provided.

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 procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage changes to prescribed medicines. However, written confirmation of one patient's new feeding regime was not in place and this was being addressed during the inspection.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

Robust arrangements were observed for the management of high risk medicines e.g. 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 and organised. The medicine refrigerator and oxygen equipment were checked at regular intervals. There was limited space in the treatment room for the storage of medicines and completion of records. We were informed that a new treatment room was being considered and plans were to be submitted to RQIA for approval.

The management of limited shelf life medicines was reviewed. The date of opening was recorded on two in use insulin pen devices and eye preparations. However, two eye preparations were removed from stock as they had passed the expiry date. This was discussed and the registered manager provided assurances that this would closely monitored.

Areas of good practice

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

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.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. A care plan was maintained. Stock levels were monitored and recorded each day; a review of these records indicated that these medicines were rarely required to be administered. 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 sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Pain management was referenced in the care plans examined. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that some of the patients could tell staff if they were in pain. However, there was limited evidence to indicate that a pain assessment tool was in place for each patient who could not express pain. An area for improvement was identified and advice given.

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.

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.

Medicine records were well maintained and facilitated the audit process.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines, the standard of record keeping and care planning. Staff were knowledgeable about the patients' medicines.

Areas for improvement

A suitable pain assessment tool should be used for those patients who cannot communicate or verbally express pain.

	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 staff, they confirmed that patients were given plenty of time to take their medicines.

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 from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes.

We spoke with one patient who advised that she had no concerns in relation to medicines and advised that she was happy in this home.

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.

The relatives we met with raised no concerns regarding the care provided.

Of the questionnaires that were distributed for patients and relatives, five were returned to RQIA. The responses received indicated that they were 'very satisfied' with the care provided. Five staff completed the online questionnaire; their responses indicated that they were 'very satisfied 'across all domains. No concerns were raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the staff listening to 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; we were advised that these were under review and development and were not examined. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

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 advised of how incidents were shared with them to inform learning and change of practice, if necessary. 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.

The auditing arrangement for medicines was reviewed. Audits were completed by the staff and management. The audits included records of running stock balances for most medicines which were not supplied in the 28 day blister packs. This is good practice. A review of the audit records indicated that largely satisfactory outcomes had been achieved. Staff advised of the procedures in place to manage any areas identified for improvement and provided details of where practice had changed.

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 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.

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 Mrs Dora Syatwinda, 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 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 21 **Stated:** First time	The registered person shall review pain management to ensure pain assessments are completed and a suitable pain assessment tool is in use. Ref: 6.5
To be completed by: 30 November 2017	**Response by registered person detailing the actions taken:** The pain management assessments have been reviewed, completed and updated which includes the implementation of a revised pain assessment tool which is now in use in the home.

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

The **Regulation** and
Quality Improvement
Authority

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