Unannounced Medicines Management Inspection Report
7 April 2017

Daisyhill Private Nursing Home

Type of Service: Nursing Home
Address: 50a Ahoghill Road, Randalstown, BT41 3DG
Tel no: 028 9447 9955
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Daisyhill Private Nursing Home took place on 7 April 2017 from 10.10 to 14.40.

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.

Information had been received from the Northern Health and Social Care Trust prior to the inspection. This raised concerns in relation to the heating and lighting in the home and the presence of domestic pets. Following discussion within RQIA it was agreed that this would be examined as part of this inspection.

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.

The home was adequately heated with appropriate lighting during the inspection.

There were no areas for 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. There were no areas for improvement identified.

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 happy with the care provided in the home and raised no issues about the presence of domestic pets in the home. There were no areas for improvement identified

Is the service well led?

The service was found to be well led with respect to the management of medicines. 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 for 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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Dr Marina Lupari, Registered Person, and Miss Colleen McWilliams, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/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 19 December 2016.

2.0 Service details

Registered organisation/registered person: Town and Country Care Homes Dr Marina Lupari	**Registered manager:** Miss Colleen McWilliams
Person in charge of the home at the time of inspection: Miss Colleen McWilliams	**Date manager registered:** 29 October 2015
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 25

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

We met with two patients, two care assistants, the registered manager and the registered person.

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.

Fifteen questionnaires were issued to patients, relatives/representatives and staff, with a request that they were returned within one week from the date of the inspection.

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 December 2016

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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection 21 November 2016

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** Second time	The registered person must ensure that records of the administration of external preparations by designated care staff are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: A separate recording system was in place to enable care staff to record the administration of external preparations. The registered manager confirmed that these records were regularly reviewed by the nursing staff.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must investigate the discrepancy highlighted at this inspection. A report of the investigation and action taken to prevent a recurrence must be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The investigation was completed and a report of the findings and action taken to prevent a recurrence was forwarded to RQIA.	

Requirement 3 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must ensure that care staff record the administration of thickening agents.	**Met**
	Action taken as confirmed during the inspection: Records for the administration of thickening agents were recorded on the daily dietary charts.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 4 **Stated:** Second time	It is recommended that care plans for the management of pain should be in place and reviewed regularly where analgesia is prescribed, to include guidance for staff on how pain may be expressed by individual patients.	**Met**
	Action taken as confirmed during the inspection: Care plans for the management of pain were in place. They included guidance for staff on how pain may be expressed by individual patients. There was evidence of regular review.	
Recommendation 2 **Ref:** Standard 31 **Stated:** First time	The registered person should review and revise the management of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: The management of controlled drugs had been revised. Each administration was witnessed. Controlled drugs were denatured prior to disposal.	
Recommendation 3 **Ref:** Standard 30 **Stated:** First time	The registered person should ensure that two registered nurses sign the records of disposal of medicines.	**Met**
	Action taken as confirmed during the inspection: A review of the records of disposal indicated that two registered nurses were involved.	
Recommendation 4 **Ref:** Standard 29 **Stated:** First time	The registered person must ensure that dates of opening are recorded on all medicines to facilitate audit and disposal at expiry.	**Met**
	Action taken as confirmed during the inspection: Dates of opening were recorded on medicine containers to facilitate audit and disposal at expiry.	

Recommendation 5 **Ref:** Standard 18 **Stated:** First time	The registered person should ensure that the details of any prescribed medicines are recorded in care plans for the management of distressed reactions when appropriate.	**Met**
	Action taken as confirmed during the inspection: A review of the care plans indicated that when medicines were prescribed for the management of distressed reactions they were recorded in the care plans.	

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 for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. The most recent training on medicines management had been provided by the community pharmacist in February 2017. The registered manager confirmed that care assistants have received training and been deemed competent to administer thickening agents and external preparations.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The registered person and registered manager advised that the community pharmacist and one of the registered nurses were involved in completing the monthly order. Prescriptions were not received into the home before being forwarded to the community pharmacy for dispensing. It was agreed that this process would be reviewed and that a photocopy of each patients' current prescriptions would be made available in the home. The secure storage of prescriptions was discussed.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. This safe practice was acknowledged.

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. Controlled drugs were observed to be administered by the registered manager/registered nurse and witnessed by a trained healthcare assistant.

Robust arrangements were observed for the management of nutrition and medicines via the enteral route.

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 at regular intervals.

Concerns had been raised by the NHSCT regarding the heating and lighting of the home. During the inspection these were found to be appropriate.

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?

With the exception of one liquid medicine, the sample of medicines examined had been administered in accordance with the prescriber's instructions. Dates of opening had been recorded on medicine containers to facilitate audit. It was agreed that liquid medicines would continue to be closely monitored.

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. The prescribed medication was referenced in the care plans for the management of distressed reactions. 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 recorded in the daily care notes.

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. Care plans for the management of pain were in place. A pain tool was in use for patients who could not verbalise their pain.

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. Care plans and speech and language assessment reports were in place. Records of administration were maintained by registered nurses on the medication administration records and on the daily dietary sheets by care assistants.

The registered manager 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. It was agreed that dividers would be placed between each patients' records on the medicines file.

Practices for the management of medicines were audited throughout the month by the staff and the registered manager. This included running stock balances for medicines which were not supplied in the monitored dosage system and nutritional supplements.

Following discussion with the registered manager, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

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.

We spoke with two patients who said that they were very happy with the care provided in the home. They stated that they had enjoyed their lunch and were looking forward to having their make-up done. They spoke fondly of a dog that sometimes visited the home and advised that the bird (kept in a cage) was removed from the room if patients did not like it.

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.

As part of the inspection process 15 questionnaires were issued to patients, relatives/ representatives and staff, with a request that they were returned within one week from the date of the inspection; none were returned within this timescale.

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?

The registered manager confirmed that written policies and procedures for the management of medicines were in place. These were not examined at the inspection.

The management of medicine related incidents was discussed in detail with the registered manager and guidance on completing the incident report forms (in a clear manner detailing what happened, why it happened and the action taken to prevent a recurrence) was provided. The registered manager confirmed that training in adult safeguarding had been provided for all staff and that staff were aware that medication related incidents may need to be reported to the adult safeguarding lead.

A review of the audit records indicated that satisfactory outcomes had been achieved. The registered manager advised that if a discrepancy was identified, it would be investigated and the findings discussed with all registered nurses for corrective action.

Following discussion with the registered manager and two care assistants, 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 or other care concerns would be raised with the management team. They confirmed that appropriate action would be taken.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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