Unannounced Medicines Management Inspection Report
7 December 2016

Ladyhill Private Nursing Home

Type of Service: Nursing Home
Address: 40 Creevery Road, Antrim, BT41 2LQ
Tel no: 028 9446 6905
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Ladyhill Private Nursing Home took place on 7 December 2016 from 10.30 to 17.00.

This was the first medicines management inspection to the home since it was re-registered in July 2016, following a change of ownership and registration of a new registered provider.

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.

Is care safe?

There was evidence that some areas of the management of medicines supported the delivery of safe care and positive outcomes for patients. Management confirmed that staff administering medicines were trained and competent. However, areas for improvement were identified in relation to training records, controlled drugs, administration of medicines and storage of medicines. To ensure that the management of medicines was in compliance with legislative requirements and standards, two requirements and three recommendations were made.

Is care effective?

Areas for improvement were identified and must be addressed to ensure that the management of medicines in this home supports the delivery of effective care. Whilst there was evidence that medicines supplied in the 28 day blister packs had been administered as prescribed, some other medicines had not been administered as prescribed and records had not been fully and accurately maintained. Where the administration of medicines was delegated to care staff, there was no records of administration. Improvement is required in the information in the patient's care files, pertaining to medicines. To ensure that the management of medicines is in compliance with legislative requirements and standards, two requirements and three recommendations have been made.

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. There was evidence of good relationships with staff. No requirements or recommendations were made.

Is the service well led?

The outcome of the inspection found that following changes in ownership and management, the service is undergoing review and development. Whilst it was acknowledged that management had identified areas for improvement and advised of the future plans, in relation to governance arrangements, there was no evidence of an effective auditing system for medicines management. As there were improvements required in the domains of safe and effective care, one requirement was made.

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	5	6

As part of the inspection process, details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Anne Clarke, Non-Executive Director, Town & Country Care Homes Ltd, at the inspection and also with Dr Marina Lupari, Registered Provider/Acting Manager, by telephone on 12 December 2016. The timescales for completion commence from the date of inspection.

The findings in relation to the management of nutrition were shared with the care inspector for the home. 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 14 September 2016.

2.0 Service details

Registered organisation/registered person: Town & Country Care Homes Limited/ Dr Marina Lupari	**Registered manager:** See below
Person in charge of the home at the time of inspection: Dr Marina Lupari until 2pm and Mr Billy Brimley (Staff Nurse) thereafter	**Date manager registered:** Dr Marina Lupari (Acting Manager - no application required)
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 31

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incidents register – it was ascertained that no medicine related incidents had been reported to RQIA since the last medicines management inspection

We met with one member of senior care staff, one pre-registration nurse, one registered nurse, one member of kitchen staff, the registered provider/acting manager and the non-executive director.

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.

Twenty-two questionnaires were issued to patients, patients' relatives/representatives and staff, with a request that these be completed and returned within one week 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
- medicine audits
- care plans
- training records
- controlled drug record book

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 September 2016

The most recent inspection of the home was an announced 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 4 November 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 29 **Stated:** First time	It is recommended that all obsolete records are removed from the current medicine folders, discontinued and securely archived.	**Met**
	Action taken as confirmed during the inspection: Obsolete medicine records have been discontinued and securely archived.	

4.3 Is care safe?

Management advised that staff had been trained in medicines management and that care staff had received training regarding medicine related tasks. They confirmed that an induction process was in place for new staff. There was no evidence of the training or competency assessments of staff available. Records which clearly state that staff have been trained and deemed competent, must be in place and kept on the premises. A requirement was made. It was advised that an up to date list of staff names and sample signatures of registered nurses and designated care staff should be maintained. The registered provider/acting manager advised that following the inspection, further training in medicines management had been arranged.

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.

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

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. Staff were reminded that when stocks of controlled drugs were disposed of or transferred, the stock balance should be brought to zero. There was evidence that stock checks were performed each morning and evening, at shift changes.

On the day of the inspection, it was noted that there had been no stock checks undertaken when the controlled drug key was transferred to the registered nurse coming on shift at 14.00. This was discussed. Some audit trails on diazepam could not be audited as the date of opening was not recorded or there were no monitoring arrangements in place. It was recommended that a system should be developed to monitor controlled drugs which are not subject to the safe custody legislation, such as diazepam.

There were instances were medicines were crushed or added to food to aid swallowing. It was not clear if pharmaceutical advice had been obtained regarding the suitability of this practice. A recommendation was made.

Discontinued or expired medicines were disposed of appropriately. Staff advised that discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. It was advised that this information should be clearly recorded in the disposal book and controlled drug record book. It was agreed that this would be recorded from the day of the inspection onwards.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean and tidy. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Some expired medicines were removed from stock on the day of the inspection. A small number of external preparations were not stored in their outer box. This was discussed in relation to infection control. Oxygen cylinders were held in the treatment room. There was no oxygen signage on the treatment room door. A recommendation regarding storage was made.

There was a supply of subcutaneous infusions held in stock. These were dispensed in 2014 and remained in date. It could not be ascertained if these were currently prescribed or had been discontinued. The registered provider/acting manager advised that she would follow this up with the patient's prescriber.

In relation to the storage temperatures for medicines, there were no records available of the temperature of the treatment room or the medicines refrigerator. A requirement was made.

Areas for improvement

Records which indicate that staff are trained and competent in the work that they perform must be maintained and kept on the premises. A requirement was made.

A system should be developed to ensure that stocks of controlled drugs which are not subject to the safe custody legislation are regularly monitored. A recommendation was made.

Pharmaceutical advice should be obtained regarding the suitability of crushing medicines or adding medicines to food or drinks to aid swallowing. A recommendation was made.

The storage of medicines should be reviewed to ensure that expired medicines are checked and removed in a timely manner, external preparations are maintained in their outer container as applicable and oxygen signage is displayed on the door of the treatment room. A recommendation was made.

Records must be maintained which demonstrate that medicines are being stored at the temperature specified by the manufacturer. A requirement was made.

Number of requirements	2	**Number of recommendations**	3

4.4 Is care effective?

Most of the medicines examined had been administered in accordance with the prescriber's instructions. However, some discrepancies were observed in liquid medicines and discussed with staff and management. There was no system to monitor stocks of nutritional supplements, and therefore it could not be ascertained if the nutritional supplements had been administered as prescribed. This was discussed in relation to their role in wound healing, patient's weight and the patient's health and well-being.

We reviewed the patient records and discussed the use of nutritional supplements with the staff. This raised concerns regarding the management of patients' nutritional supplements (as mentioned above) and the management of weight loss. Staff confirmed that patients' nutrition was under review and they advised of the procedures that had been recently adopted to fortify foods/drinks. This information was shared with RQIA's care inspector for the home. A requirement regarding the auditing process for medicines was made in Section 4.6.

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 three times weekly, 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. 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. Of the sample of records examined, there had been no recent administration. Whilst there was a care plan regarding behaviours and an assessment tool was in place which described how the patient would express distressed reactions, the care plan did not refer to the medicine prescribed. This should be clearly stated. A recommendation was made.

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 some of the patients could verbalise any pain, and a pain assessment tool was used as needed. In relation to care plans, these were maintained for some but not all patients prescribed pain controlling medicines. A recommendation was made.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was not always recorded on their personal medication record and did not always include the details of the fluid consistency. Records of administration were incomplete and there was no system in place to enable care staff to record administration. Although there was evidence of care plans and corresponding speech and language assessments, for one patient it could not be ascertained if the thickened fluid was currently prescribed. It was agreed that this would be reviewed with immediate effect. It was noted that patients were not administered their thickening agent from their own supply. Medicines should not be shared and this should be reviewed. A requirement regarding the management of thickening agents was made.

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.

Some of the medicine records were well maintained and facilitated the audit process. In relation to the records of prescribing and administration of external preparations, improvements were required. The dosage directions must be clearly stated. When administered by care staff, records of administration were not maintained. It could not be determined if the external preparation had been administered as prescribed. Management stated that this area of medicines had been recently identified for improvement. A requirement was made. A small number of missing entries were noted on the administration records and reported to the registered provider/acting manager.

The management of records regarding enteral feeding was reviewed. Feeding regimes were in place and fluid intake charts were maintained. The format of the chart should be reviewed to ensure that the quantity of enteral feed administered and total daily fluid intake are recorded, and therefore enable staff to ensure the target volume intake has been achieved. A recommendation was made.

Following discussion with the management and staff, it was evident that when applicable, other healthcare professionals were contacted in response to medicines management.

Areas for improvement

Care plans regarding the management of distressed reactions should be further developed. A recommendation was made.

In the instances where pain controlling medicines are prescribed, a care plan should be maintained. A recommendation was made.

Robust arrangements for the management of thickening agents must be in place. A requirement was made.

The management of external preparations must be reviewed to ensure that records are fully and accurately maintained. A requirement was made.

The format of the fluid intake charts pertaining to enteral feeding should be reviewed. A recommendation was made.

Number of requirements	2	Number of recommendations	3

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.

It was not possible to ascertain the views and opinions of patients.

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. There was evidence of good relationships between the staff and the patients.

Patients were observed to be enjoying the musical activities which were provided during the inspection.

As part of the inspection process, questionnaires were issued to patients, patients' relatives/representatives and staff. Three patients and one member of staff completed and returned questionnaires. The responses were recorded as 'very satisfied' or 'satisfied' with medicines management in the home.

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?

Management confirmed that written policies and procedures for the management of medicines were in place, however, advised that these were under review and development following the change in ownership. These were not examined at the inspection.

As part of the new governance structure in the home, the registered provider/acting manager advised of the non-executive director's role in monitoring incident management and audit activity in the home.

There were largely satisfactory arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. There had been no reported medicine related incidents since the last medicines management inspection. However, one recently identified issue regarding the lack of signatures in the controlled drug record book was discussed. Details of the action taken and the learning from this incident were provided.

There was limited evidence to indicate that a robust auditing process for medicines management was in place. A number of audit trails could not be completed due to the standard of record keeping and there were discrepancies in some medicines as referred to in Section 4.4. The audit records were reviewed and the last audits recorded were dated May 2016. Due to the inspection findings a requirement was made.

Following discussion with management 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.

Areas for improvement

A robust auditing process for the management of medicines must be developed and implemented. A requirement was made.

Number of requirements	1	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Anne Clarke, Non-Executive Director, Town & Country Care Homes Ltd and also with Dr Marina Lupari, Registered Provider/Acting Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the Web Portal for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref**: Regulation 19(3) **Stated:** First time **To be completed by:** 7 January 2017	The registered provider must ensure records of training and competency are maintained and available in the home.
	Response by registered provider detailing the actions taken: Training records now moved from Head Office and a copy held in LadyHill PNH.
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 7 January 2017	The registered provider must ensure that records which indicate that medicines are being stored at the temperature specified by the manufacturer are maintained.
	Response by registered provider detailing the actions taken: New fridge temperature audit system introducted and recorded twice daily by Registered Nurse.

Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 7 January 2017	The registered provider must ensure robust arrangements are put in place for the management of thickening agents.
	Response by registered provider detailing the actions taken: New monitoring system in place through the use of regional fluid balance chart for recording. Prescription managed through introduction of supplements kardex. Staff training in place.
Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 7 January 2017	The registered provider must ensure robust arrangements are put in place for the management of external preparations.
	Response by registered provider detailing the actions taken: New system introduced based on topical administration kardex to be delegated and signed by Care Assistants. Training in place to enable Care Assistants to gain the required competencies.
Requirement 5 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 7 January 2017	The registered provider must develop and implement a robust auditing process for medicines management.
	Response by registered provider detailing the actions taken: Registered Nurse Matthews will assume role as lead nurse. Boots will also audit on a 3 monthly basis. Specific areas will be identified each month to be audited.
Recommendations	
Recommendation 1 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 7 January 2017	The registered provider should develop a system which enables the monitoring of controlled drugs which are not subject to the safe custody legislation.
	Response by registered provider detailing the actions taken: Safe Custody Drug log introduced for all schedule 3 and 4 drugs.
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 7 January 2017	The registered provider should ensure that there is evidence that pharmaceutical advice has been obtained regarding the suitability of crushing medicines or adding medicines to food or drinks to aid swallowing.
	Response by registered provider detailing the actions taken: Registered Nurse Matthews will idenitfy specific medicines being crushed for one specific respire resident. These medicines are all added to Peg Feed. No other meds are crushed for any other resident.

Recommendation 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 7 January 2017	The registered provider should review the storage of medicines are detailed in the report.
	Response by registered provider detailing the actions taken: Sunday checks introduced.
Recommendation 4 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 7 January 2017	The registered provider should further develop the care plans regarding medicines prescribed for distressed reactions.
	Response by registered provider detailing the actions taken: As an ongoing review of care plans for all residents this will be introduced.
Recommendation 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 7 January 2017	The registered provider should ensure that where pain controlling medicines are prescribed, this is referenced in a care plan.
	Response by registered provider detailing the actions taken: As an ongoing review of care plans for all residents this will be introduced.
Recommendation 6 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 7 January 2017	The registered provider should review the format of fluid intake charts pertaining to enteral feeding.
	Response by registered provider detailing the actions taken: The regional fluid balance chart has been adopted for the recording of fluid intake pertaining to the enteral feeding. Daily totaling of all charts is now completed by night shift and recorded in residents charts.

Please ensure this document is completed in full and returned to the RQIA web portal

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