Unannounced Medicines Management Inspection Report
23 January 2018

Ladyhill Private Nursing Home

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

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 servicefrom 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 homewith 31 beds that provides care for patients living with a learning disability.

3.0 Service details

Organisation/Registered Provider: Town & Country Care Homes Limited **Responsible Individual:** Dr Marina Lupari	**Registered Manager:** See box below
Person in charge at the time of inspection: Ms Lisa Craig	**Date manager registered:** Ms Lisa Craig - Acting - no application required
Categories of care: Nursing Homes (NH): LD – Learning disability LD(E) – Learning disability – over 65 years	**Number of registered places:** 31

4.0 Inspection summary

An unannounced inspection took place on 23 January 2018 from 10.10 to 14.35.

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 medicines administration, management of medicine changes, medicine storage and controlled drugs.

Areas requiring improvement were identified in relation to record keeping and medicine related incidents.

Patients were noted to be content in their surroundings and in their 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.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Ms Lisa Craig, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcementaction did not result from the findings of this inspection.

4.2Action/enforcementtaken following the most recent financeinspection

Other than those actions detailed in the QIPno further actions were required to be taken following the most recent inspection on 26 October 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 incidents; it was ascertained that no medicine related incidents had been reported to RQIA since the last medicines management inspection.

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

During the inspectionwe met with twopatients, one member of staff and the manager.

Ten questionnaires were provided for distribution to patients and their representatives 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 improvementidentified 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 theinspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 26 October 2017

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was approved by the finance inspector. This QIP will be validated by the finance inspector at the next finance inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 28 March 2017

Areas for improvement from the last medicines management inspection		
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 29 **Stated:** Second time	The registered provider should review the format of fluid intake charts pertaining to enteral feeding.	**Met**
	Action taken as confirmed during the inspection: An improvement in the completion of these records was evidenced. A new format of fluid intake chart had been developed and implemented. This included the administration of medicines, flushes with water and the total daily fluid intake.	

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. A sample of training records was provided, including records of care staff appraisal. The impact of training was monitored through team meetings, supervision and annual appraisal. Staff confirmed that competency assessments were

completed for the registered nurses by the registered provider on an annual basis. The manager advised that refresher training in medicines management and enteral feeding was planned for later this year.

The ordering and stock control systems for medicines were reviewed. Although staff advised of the procedures to identify and report any potential shortfalls in medicines, we noted that two eye preparations had been out of stock for 10 daysin December 2017. This had not been addressed or reported to management in a timely manner and the patient's prescriber had not been contacted. It was agreed that the prescriber would be contacted after the inspection. See also Section 6.7.

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

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training was completed on an annual basis.

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. The benefit of maintaining stock balances on other controlled drugs which do not require safe custody was discussed e.g. diazepam.

Largely satisfactory arrangements were observed for the management of high risk medicines e.g. anticoagulants and insulin. However, an apparent discrepancy was noted in the administration records for one anticoagulant injection. The manager was requested to look into this; she provided details by email on 30 January 2018. The findings indicated that there was no actual discrepancy but that there had been a recording error and all staff had been made aware.

In the instances when medicines were administered in food to assist with the swallowing, a care plan was in place.

Discontinued or expired medicines were disposed of appropriately. Two staff were usually involved in the disposal of medicines. Staff advised that this was the expected practice and agreed to remind staff to ensure that this occurred on every occasion.

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. The medicine refrigerator and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training, the management of medicines on admission and controlled drugs.

Areas for improvement

No areas for improvement were identified during this 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.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. The administration of a few medicines which should be closely monitored was highlighted to staff. The manager advised that these would be included in the audit process.

There was evidence that where medicines were prescribed on an alternate day or weekly basis, the days of administration were clearly marked out on the medication administration records (MARs). In relation to bisphosphonate medicines, staff confirmed that they were administered separately from food or other medicines. It was agreed that staff would be reminded to record the actual time of administration.

Care plans regarding the management of epilepsy were maintained.

A small number of patients were prescribed medicines on a 'when required' basis, to manage distressed reactions. These medicines were rarely required. The patient's personal medication record included the dosage directions and a care plan was maintained. In addition a separate protocol was in place to enable staff to record the reason for and the outcome of any administration.

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 not communicate pain. They confirmed that a pain assessment tool was used as needed. Details of pain management were recorded in the patient's care plan.

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.

A care plan regarding enteral feeding was in place. Fluid intake charts detailed that the administration of medicines was accompanied by flushes of water and the total 24 hour intake. See also Section 6.2.

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. They provided details when a medicine formulation had been changed to assist with the patient's compliance.

Most of the medicine records were well maintained and facilitated the audit process. In relation to personal medication records, staff should ensure that obsolete records are discontinued and archived, all new medicines are added to the current record; and when medicines are discontinued, this is clearly documented. An area for improvement was identified. The completion of MARs was also discussed. Whilst most of these were well maintained, it was found that not allhandwritten MARsincluded the start date and medicine entries were not signed by two members of staff to ensure accuracy. For one patient the record indicated that the incorrect dose of one medicine was being administered. On further review, it was concluded that this was a recording error and the patient had been administered the correct dose.An area for improvement was identified.

On occasion, medicines were supplied in seven day blister packs; some, but not all of these were clearly identifiable by colour, shape and code. This was discussed and the manager agreed to raise with staff and also contact the community pharmacy, as necessary.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for most tablets and capsules which were not contained with the 28 day blister pack system; and also staff had recorded the stock balance of some medicines which were carried forward to the new medicine cycle. These records readily facilitated the audit process and were acknowledged. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff, and a review of the care files, 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 care planning and the administration of medicines. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The management of personal medication records should be reviewed to ensure that robust arrangements are in place.

Staff should ensure that when handwritten medication administration records are brought into use, these include the start date and each medicine entry is signed by two staff, to confirm the accuracy of the entry.

	Regulations	Standards
Total number of areas for improvement	0	2

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 a small number of patients was observed at the inspection. It was found that the medicines were administered in a caring manner and as discreetly as possible. The patients were given time to take their medicines.

Following discussion with staff they provided examples of when medicines were administered at a later or earlier time to facilitate the patients' preferences/needs; and confirmed that they were aware of and adhered to the prescribed time intervals between 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.

It was not possible to ascertain the views and opinions of patients in relation to the management of their medicines. However, we met briefly with a few patients and one patient commented:

"I love the dinners here."
"I am happy."

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.

Of the ten questionnaires which were left in the home to facilitate feedback from patients and their relatives, none were returned within the specified timescale (two weeks).

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 in place. These were not examined in detail. 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 largely satisfactory arrangements in place for the management of medicine related incidents. Whilst staff confirmed that they knew how to identify and report incidents, the out of stock situations identified at this inspection had not been considered as incidents or the impact that this may have for the patient. An area for improvement was identified.

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.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. When a discrepancy occurred, staff advised of the procedures in place to share this with staff and change practice as necessary.

Following discussion with the 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 any resultant action was communicated with them through team meetings, staff notices and supervision.

There were no questionnaires completed by staff within the specified timescale (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

The management of incidents should be reviewed with staff.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of theQIP were discussed with Ms Lisa Craig, 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 standardsthis 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 improvementidentified 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 providershould confirm that these actions have been completed and return the completed via theWeb 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:** 23 February 2018	The registered person shall put robust systems in place for the management of personal medication records. Ref: 6.5
	Response by registered person detailing the actions taken: The registered person has created a standard operating procedure which states that all obsolete records should be discontinued and archived. All new medicines should be added to current records and when medicines are discontinued this should be clearly documented on the medication record and a discontinuation date recorded. This has been communicated to all Registered Nursing staff
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 23 February 2018	The registered person shall review the completion of medication administration records as detailed in the report. Ref: 6.5
	Response by registered persondetailing the actions taken: The registered person has created a standard operation procedure for handwritten medication administration records, which states clearly that when the same are brought into use they should include a start and end date and each medicine entry should be signed by two members of staff, to confirm the accuracy of the entry. This has been communicated to all Registered Nursing staff
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 23 February 2018	The registered person shall review the management of incidents. Ref: 6.7
	Response by registered persondetailing the actions taken: The registered person has created a new standard operation procedure which clearly states the nature of situations that should be identified as incidents and reported to the Registered Manager and RQIA.This has been communicated to all Registered Nursing staff

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

The Regulation and Quality Improvement Authority

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