Unannounced Medicines Management Inspection Report
19 February 2019

Ladyhill Private Nursing Home

Type of Service: Nursing Home
Address: 40 Creevery Road, Antrim, BT41 2LQ
Tel No: 02894466905
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 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 that provides care for up to 31 patients living with alearning disability.

3.0 Service details

Organisation/Registered Provider: Town and Country Care Homes Ltd **Responsible Individual:** Dr Marina Lupari	**Registered Manager:** See box below
Person in charge at the time of inspection: FiFi Kouraku, Registered Nurse	**Date manager registered:** Dr Marina Lupari (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 19 February 2019 from 10.30 to 15.20.

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 auditing systems, training and competency, medicines administration, the completion of most medicine records, medicines storage and the management of controlled drugs.

Two areas for improvement were identified regarding the management of warfarin and records of incoming medicines.

Patients were observed to be relaxed and comfortable in their environment and interactions with staff. The patientsthat we met with spoke positively about the home.

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	2

Details of the Quality Improvement Plan (QIP) were discussed with Ms FiFi Kourakou, Nurse in Charge, and Dr Marina Lupari, Registered Person, 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 13 December 2018.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: 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 by RQIA was being conducted.

During the inspectionwe met with two patients, one care assistant, one registered nurse, the administrator, the operations manager and the registered person, who was present for feedback at the end of the inspection.

We provided 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA; we asked the manager to display a poster which invited staff to share their views and opinions 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
- care plans
- training records
- medicines storage temperatures

We left ‘Have we missed you?’ cards in the home to inform patients and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

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 13 December 2018

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 23 January 2018

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:** First time	The registered person shall put robust systems in place for the management of personal medication records.	**Met**
	Action taken as confirmed during the inspection: Improvement in the completion of personal medication records was evidenced. These were dated and signed by two registered nurses and were checked as part of the monthly audit process.	
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered person shall review the completion of medication administration records as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: A new system to record the administration of medicines had been implemented in the last few months. These records were well maintained and reasons for any omissions were clearly stated.	

Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the management of incidents.	**Met**
	Action taken as confirmed during the inspection: The management of incidents had been reviewed with staff. They advised of the procedures followed in the event of an incident being identified; and in relation to medicines, were aware of what needed to be reported.	

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. Refresher training in medicines management was provided each year and was included within the mandatory training programme. Other training completed this year included the management of swallowing difficulty, dementia, diabetes and enteral feeding.

A new medicine system had been introduced in the last few months. Staff advised that this was working well. Safe systems were in place to ensure that patients had a continuous supply of their medicines. Newly prescribed medicines had been received into the home without delay.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and for the management of medicine changes. Personal medication records were updated by two staff which is safe practice. Staff advised that any changes to medicines were also highlighted in the communication book and at shift handover.

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

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.

The management of high risk medicines was examined e.g. warfarin. A care plan was in place. Staff maintained a separate administration record which included two staff signatures for each administration;this safe practice was acknowledged. In relation to the warfarin dosage regime this was received by telephone by one registered nurse. To ensure safe systems, two trained staff should hear any telephoned instructions, the dosage instructions should be followed up in writing,

and any transcribing on the warfarin administration records should involve two trained staff. An area for improvement was identified.

Epilepsy management plans were in place for patients prescribed rescue medicines for the treatment of seizures.

Some tablets were required to be crushed prior to administration. There was evidence that this had been discussed with the prescriber and a letter of consent was kept in the patient's medicine file.

There were satisfactory arrangements in place for the safe disposal of medicines.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. A new storage system had been implemented which enabled clear segregation of each patient's medicines. 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, competency assessment, the management of medicines on admission and controlled drugs.

Areas for improvement

The management of warfarin should be reviewed to ensure that robust systems are in place.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Staff advised of changes in the administration of medicine process to ensure that distractions were prevented and to ensure safe administration. Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. A few discrepancies were observed and discussed for close monitoring as part of the audit process.

There were arrangements in place to alert staff of when doses of weekly medicines were due. There was evidence that time critical medicines had been administered at the correct time e.g. bisphosphonates.

The administration of medicines via an enteral feeding tube was examined. Written confirmation of the dosage regime was in place and details of the administration of the enteral feed, medicines and flushes were recorded.

Most of the medicine records were well maintained and facilitated the audit process. However, improvements in the completion of records regarding incoming medicines are necessary. We noted that the date of receipt was not documented and records of medicines received outside of the monthly order were not maintained. An area for improvement was identified. The patient's

photograph was not locatedwiththeir personal medication record; staff advised that this was an oversight following the introduction of the new medicines system and that these photographs were held electronically. It was agreed that this would be addressed.

The management of pain and distressed reactions was examined. Medicines details were clearly recorded on the personal medication records and the relevant care plans were maintained. 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. Pain assessment tools were used for those patients who could not tell staff if they were in pain. Separate administration records were maintained for the medicines which were prescribed on a "when required" basis and they included the reason for and the outcome of administration.In relation to distressed reactions, these medicines were rarely required. The manager advised of the planned improvements being implemented in relation to care plans for pain management.

Some patients were prescribed thickening agents to manage swallowing difficulty.The thickening agent was recorded on their personal medication record, but did not include the details of the fluid consistency. The need for this was discussed and it was agreed that it would be documented. We acknowledged that following discussion with the staff they were knowledgeable regarding the prescribed consistency level. 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.

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

Areas of good practice

There were examples of good practice in relation to the completion of most medicine records, care planning and the administration of medicines.

Areas for improvement

The necessary arrangements should be made to ensure that details of all incoming medicines are recorded.

	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 were knowledgeable regarding the patients' medicines.

Throughout the inspection, it was evident that there was a good rapport between patients and staff and that staff were familiar with the patients' likes and dislikes. The staff treated the patients with respect and their approach was friendly and kind. They listened to the patients' requests.

We spoke with two patients at the inspection. We could not obtain their views or opinions about medicines management; however, they advised that they were "happy here" and the food was "very nice".

We observed the patients to be relaxed and comfortable in their surroundings and interactions with staff.

Of the questionnaires which we left for patients and their representatives, one was returned within the specified time frame (two weeks). The responses were recorded as "very satisfied" with the care in the home. One comment was made:

"All xxx (patient) needs are met with great care."

Any comments in questionnaires received after the return date will be shared with the manager as necessary.

Areas of good practice

Staff listened to patients 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.

We discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. Arrangements were in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

The governance arrangements for medicines were reviewed. Daily, weekly and monthly audits were completed. These included a variety of medicine formulations and the maintenance of running stock balances for several medicines.We were advised that this system enabled staff to readily identify any discrepancies. There was evidence that this system was well embedded into

routine practice. Staff advised of the procedures that were followed if a discrepancy was identified.

There were robust arrangements in place for the management of medicine related incidents. See Section 6.2. 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.

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 were raised with management.

The staff we met with spoke positively about their work in the home and advised there were good relationships and team working. They stated they had no concerns.

No online questionnaires were completed by staff within the specified time frame (two weeks).

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 theQIP were discussed with and Ms FiFi Kourakou, Nurse in Charge,and Dr Marina Lupari, Registered Person, 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 withthe Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 21 March 2019	The registered person shall review the management of warfarin as detailed in the report. Ref: 6.4
	Response by registered person detailing the actions taken: A standard operating procedure has been developed for the management of warfarin. RQIA shared a warfarin template that was fully compliant with all their requriements. This replaced the Warfarin form that was being used and warfarin management is fully compliant with RQIA requirements
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 21 March 2019	The registered person shall ensure that records of incoming medicines are fully and accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: An amended incoming medications recording system has been introduced which clearly records adhoc medications and the date that they are received.

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

The Regulation and Quality Improvement Authority

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