Unannounced Medicines Management Inspection Report
19 September 2018

Broadways Private Nursing Home

Type of Service: Nursing Home
Address: Broadway, Main Street, Larne, BT40 1LT
Tel No: 028 2827 3464
Inspector: Rachel Lloyd

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 registered to provide nursing care for up to 33 patients.

3.0 Service details

Organisation/Registered Provider: Broadways Private Nursing Home Ltd. **Responsible Individuals:** Mrs Barbara Sloan	**Registered Manager:** Mrs Jacqueline Davey
Person in charge at the time of inspection: Mrs Jacqueline Davey	**Date manager registered:** 7 March 2012
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment	**Number of registered places:** 33 Including a maximum of two patients in category NH-PH

4.0 Inspection summary

An unannounced inspection took place on 19 September 2018 from 10.05 to 14.45.

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 staff training, most medicine records, the management of controlled drugs and staff listening to and taking into account the views of patients and relatives.

Three areas for improvement were identified, in relation to the management of self-administration, the management of eye preparations for one patient and the management of distressed reactions.

Patients were relaxed and comfortable in the home and good relationships with staff were evident. The patients and relative spoken to advised that they were satisfied with the management of medicines and the care provided in 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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Jacqueline Davey, 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 premises inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 13 August 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 any medicine related incidents - it was ascertained that no incidents involving medicines had been 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 four patients in the lounges after lunch, one relative, one registered nurse, one pre-registration nurse and the registered manager.

We provided the registered manager with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. 'Have we missed you?' cards were left in the foyer of the home to inform patients/their representatives of how to contact RQIA, to tell us of their experience of the quality of care provided. Flyers providing details of how to raise any concerns were also left in the home.

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 asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

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 13 August 2018

The most recent inspection of the home was an announced premises inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 26 September 2017

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:** First time	The registered person shall ensure that medicine administration records are accurately maintained at all times.	**Met**
	Action taken as confirmed during the inspection: Medicine administration records for August and September 2018 were examined and with the exception of an occasional missing signature, which was discussed with staff, they were found to be satisfactorily maintained.	
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 30 **Stated:** Second time	The registered provider should ensure that handwritten entries on printed medicine administration records are signed and are verified by a second competent member of staff to ensure accuracy in transcription.	**Met**
	Action taken as confirmed during the inspection: The majority of additions to these records had been signed by a second member of staff. Staff had been advised that the signature of a trained and competent care assistant is acceptable when a second registered nurse is not present. Staff reminder notices were observed regarding this. The registered manager agreed to remind staff that this is necessary on every occasion to ensure accuracy of records.	

Area for improvement 2 **Ref**: Standard 28 **Stated:** Second time	The registered provider should review procedures for the disposal of controlled drugs to ensure that controlled drugs in Schedule 4 (Part1) are denatured and rendered irretrievable prior to disposal.	**Met**
	Action taken as confirmed during the inspection: This had been addressed. A separate controlled drug destruction record was maintained which included examples of these medicines being denatured. The disposal bin was secured and the nurse in charge carried the key.	
Area for improvement 3 **Ref**: Standard 29 **Stated:** Second time	The registered provider should ensure that a second competent member of staff verifies and signs the record of the disposal of medicines.	**Met**
	Action taken as confirmed during the inspection: Staff advised that this was routine practice. Two members of staff had signed the record of disposal.	
Area for improvement 4 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the management of warfarin to ensure that administration records and stock balance records are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: The administration and stock balance records for two patients were examined and found to be satisfactorily maintained.	
Area for improvement 5 **Ref**: Standard 28 **Stated:** First time	The registered person shall review audit procedures to ensure that areas for improvement identified are examined, and that the QIP is regularly reviewed as part of the quality improvement process to ensure immediate and ongoing compliance.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that the QIP has been reviewed regularly since the last inspection and that this has proved useful. Areas for improvement identified at the last medicines management inspection had been satisfactorily addressed.	

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 the pre-registration nurse who was working under the supervision of a registered nurse. Care assistants had received training and been deemed competent to administer thickening agents and emollient preparations. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in medicines management was provided in the last year. Competency assessments were completed annually.

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

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 had been received into the home without delay. Staff were reminded to check the stock levels of medicines not included in the monitored dosage system before ordering on every occasion, to prevent overstock accumulating and to prevent wastage.

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 members of staff (see Section 6.2).

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. Additional checks were also performed on other controlled drugs which is good practice.

Mostly satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. However, for one patient, written confirmation of the current warfarin dose was not in place. Staff were reminded that if dose regimens are taken by phone then two trained members of staff should be involved in recording and transcribing these to ensure accuracy.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured prior to disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and 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. The medicine refrigerator temperature

during the inspection was satisfactory. However, staff were advised that the medicines refrigerator temperatures displayed by the refrigerator thermometer and those recorded on a daily basis by staff did not correlate. This was discussed with the registered manager who agreed to remind all staff how to correctly operate the thermometer and complete records accurately.

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

No areas for improvement were identified.

	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 management of the self-administration of medicines was examined and staff were advised that this is to be encouraged where possible. A few patients stored inhalers and creams in their bedrooms and self-administered these medicines, sometimes with assistance from staff and sometimes independently. This was not reflected in records and nurses had routinely signed the records of administration. The self-administration of medicines should be reviewed to ensure that this is promoted whilst ensuring that it is detailed in the care plan, recorded appropriately on medicine records and that patients have appropriate storage arrangements. An area for improvement was identified.

The sample of medicines examined had mostly 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, monthly or three monthly medicines were due. However, for one patient it was unclear if three different eye preparations had been administered as prescribed. These were not recorded on the personal medication record or medicines administration record. Two of these were observed in stock but did not appear to be in use. The registered manager agreed to investigate this and report the outcome to the patient, the prescriber and RQIA. An area for improvement was identified.

The management of pain and dysphagia was reviewed and found to be satisfactory.

A number of patients were prescribed medicines for use 'when required' in the management of distressed reactions. Several were receiving these medicines on a daily basis, sometimes at the patient's request. The prescriber should be made aware of frequent use and that this should be recorded. A care plan was not in place and no record of the reason for and outcome of each administration was maintained. An area for improvement was identified.

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 discussed with the patient and reported to the prescriber.

Medicine records were mostly well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of additional records for transdermal patches.

Practices for the management of medicines were audited regularly. In addition, audits were completed by the community pharmacist. Good outcomes were recorded in these records. The registered manager was advised to include the issues highlighted in this report in auditing procedures.

Following discussion with the staff on duty and a review of the care plans, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

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

Areas for improvement

The self-administration of medicines should be reviewed to ensure that this is detailed in the care plan, that it is recorded appropriately on medicine records and that patients have appropriate storage arrangements.

The management of eye preparations for one patient should be investigated and the outcomes reported as necessary.

The management of distressed reactions should be reviewed to ensure that a patient specific care plan is maintained, that the prescriber is made aware of frequent use and the reason for and outcome of administration is recorded on every occasion.

	Regulations	Standards
Total number of areas for improvement	0	3

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.

We observed the administration of medicines to a small number of patients in the morning and at lunchtime. The registered nurse engaged the patients in conversation and explained that they were having 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. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes. Patients were observed to be relaxed and comfortable.

We spoke with four patients and one relative who were complimentary regarding the care provided and the staff in the home. The patients and relative spoken to advised that they were satisfied with the management of medicines.

Ten questionnaires were left in the home to facilitate feedback from patients and their representatives. Seven were returned within the specified timescale (two weeks). They all indicated that they were satisfied/very satisfied with the care provided.

Comments included:
"I visit my wife every day and she is loved and much looked after."
"Jackie always helps the staff get me anything I want."

Any comments from patients and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

There was evidence that 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.

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. They were not reviewed on this occasion. Following discussion with staff it was evident that they were familiar with policies and procedures and that any updates were highlighted to staff.

There were arrangements in place for the management of any medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Staff were reminded that if prescribed medicines, including the eye preparations discussed in section 6.5, have been omitted this may need to be reported to the safeguarding team and the care manager should be contacted.

A review of the audit records indicated that mostly satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the nurses on duty, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date.

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

Areas of good practice

There were 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 Jacqueline Davey, 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 the 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 28 **Stated:** First time **To be completed by:** 19 October 2018	The registered person shall ensure that there are robust systems in place to manage the self-administration of medicines. Ref: 6.5
	Response by registered person detailing the actions taken: The system used for self administration of medicines has been reviewed and more stringent measures applied. Care plans of Residents self administration of medications have been adjusted. All nursing staff received a nursing learning memo regarding policy on self administration of medicines.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 19 October 2018	The registered person shall ensure that the management of eye preparations for one patient is investigated and the outcomes reported as detailed in the report. Ref: 6.5
	Response by registered person detailing the actions taken: The Manager liaised with the Residents G.P. and his family regarding correct prescription of eye drops. Desired outcome obtained. As this was a recently admitted Resident, staff were informed of the importance of requesting a print out of medications from the G.P. when Resident is admitted from home.
Area for improvement 3 **Ref**: Standard 18 **Stated**: First time **To be completed by:** 19 October 2018	The registered person shall review the management of distressed reactions to ensure that a patient specific care plan is maintained, that the prescriber is made aware of frequent use and the reason for and outcome of administration is recorded on every occasion. Ref: 6.5
	Response by registered person detailing the actions taken: All Residents requiring PRN medication for conditions causing distress have a care plan detailing this. Staff monitor the frequency of PRN medication and advise medical staff when the PRN becomes a regular occurance allowing the GP to make an informed decision as to whether or not the medication is prescribed on a daily basis. The Manager audits the PRN medications at least once monthly.

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

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