Unannounced Medicines Management Inspection Report
19 August 2018

Drapersfield House

Type of Service: Nursing Home
Address: 19 Drapersfield Road, Cookstown, BT80 8RS
Tel No: 028 8676 4868
Inspector: Catherine Glover

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 with 45 beds that provides care for patients with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Drapersfield House Ltd **Responsible Individual:** Mrs Jill Canavan	**Registered Manager:** Mrs Margaret Kolbohm
Person in charge at the time of inspection: Ms Sinead Rooney, Nurse in Charge	**Date manager registered:** 16 June 2016
Categories of care: Nursing Homes I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 45

4.0 Inspection summary

An unannounced inspection took place on 19 August 2018 from 09.50 to 13.15.

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 medicine records and storage.

Areas for improvement were identified in relation to reviewing the risks associated with the current medicines system and recording the reasons for and outcome of administering medicines for distressed reactions.

Patients told us they were happy in the home and that the staff were excellent.

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	1	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Margaret Kolbohm, Registered Manager by telephone on 20 August 2018. A meeting to discuss the system in place for administering medicines was held with Mrs Jill Canavan, Registered Person and Mrs Margaret Kolbohm, Registered Manager, on 23 August 2018. 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 care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 21 July 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 medicine related incidents 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 and two registered nurses.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA.

We asked the nurse in charge to display a poster in the home inviting staff to share their views of the home by completing an online questionnaire.

We left “Have we missed you?” cards. The cards facilitate patients or relatives who were not present at the time of the inspection to give feedback to RQIA on the quality of service provision. Flyers which gave information on raising a concern 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
- medicine audits
- care plans
- medicines storage temperatures

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 21 July 2018

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

6.2 Review of areas for improvement from the last medicines management inspection dated 26 October 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 ensure that personal medication records and updates to this record are verified and signed by two registered nurses.	**Met**
	Action taken as confirmed during the inspection: Personal medication records and updates were routinely signed by two registered nurses.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the arrangements in place for the supply of medicines to ensure that there is a consistent system for each patient and across the home.	**Not met**
	Action taken as confirmed during the inspection: There had been no change to the systems that were in place. This was discussed with the registered person and registered manager at a meeting on 23 August 2018. See section 6.5. This area for improvement has been escalated to an area for improvement with relation to the regulations.	

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. 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 in the last year. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

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. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged.

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

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The medicine refrigerator and oxygen equipment were checked at regular intervals. Staff were reminded that the thermometer for the medicine refrigerator should be reset daily.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the 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.

The sample of medicines examined had 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 or three monthly medicines were due.

The medicines management inspections of 6 March 2017 and 26 October 2017 found that management had begun to implement a change in the supply of medicines to the home. The implementation of the new system had not yet been completed at this inspection. The system was still not consistent across each patient and the registered provider had previously given assurance that this process would be reviewed. The inconsistency in the system could lead to an error when medicines are being administered. This was discussed in detail with the registered person and registered manager at a meeting on 23 August 2018. It was agreed that the management of the home would ensure a robust system is implemented. An area for improvement was identified.

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. A care plan was maintained. The reason for and the outcome of administration were not always recorded. An area for improvement was identified.

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 verbalise any pain, and a pain tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

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.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included additional records for recording the administration of analgesia.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines.

Following discussion with the registered nurses, it was evident that other healthcare professionals are contacted when required to meet the needs of patients.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping and care planning.

Areas for improvement

The system in place for administering medicines must be robust.

When medicines are administered on a "when required" basis for the management of distressed reactions, the reason for and outcome of the administration should be recorded.

	Regulations	Standards
Total number of areas for improvement	1	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 during this inspection, however staff were knowledgeable regarding the patients' medicines and requirements.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were noted to be friendly, courteous and happy in their work; they treated the patients with dignity.

We spoke to four patients who advised that they were happy in the home and that the staff were good. Comments included:

"The staff are fantastic."
"I like it here."
"I have settled in well."
"The food is good and there is plenty of it."

Four questionnaires were returned from patients. All stated that they were satisfied or very satisfied with the care provided to them. Comments included:

"I am treated very well and I have no complaints."
"I am happy with the care I receive."
"I am well looked after."

Areas of good practice

Staff were engaged with patients and we were told that the registered manager was very approachable.

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 are 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 staff.

We had previously raised concerns about the supply of medicines to the home. This was discussed with the management after the inspection and an area for improvement made (see section 6.5)

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents. 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 satisfactory outcomes had been achieved.

Following discussion with the registered nurses 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 the registered manager was approachable and willing to listen.

There were no responses to the online staff questionnaire.

Areas of good practice

There were examples of good practice in relation to governance arrangements and the management of medicine incidents. 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 the QIP were discussed with Mrs Margaret Kolbohm, Registered Manager, by telephone on 20 August 2018. 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 19 September 2018	The registered person shall ensure that the system in place for administering medicines is robust. Ref: 6.5
	Response by registered person detailing the actions taken: The implementation of the new system for administering medication is now fully complete and is consistent across each patient, we are no longer operating a dual system. Early 2019 we plan that all future medication will be dispensed/supplied from the pharmacist in a new robust pill pac plus system.
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:** 19 September 2018	The registered person shall ensure that when medicines are administered on a “when required” basis for the management of distressed reactions, the reason for and outcome of the administration is recorded. Ref: 6.5
	Response by registered person detailing the actions taken: All registered nurses have been reminded to ensure, that the reason and the outcome of administration for "when required" medication is recorded correctly in full, on the mar sheet comment column and in the patient’s daily evaluation sheet.

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

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