Unannounced Medicines Management Inspection Report
3 January 2018

Chester

Type of Service: Nursing Home
Address: 27-29 Chester Avenue, Whitehead, BT38 9QQ
Tel No: 028 93353060
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 43 beds that provides care for patients and residents with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Chester Homes Ltd **Responsible Individual:** Mr Colin Nimmon	**Registered Manager:** Ms Gillian Dowds
Person in charge at the time of inspection: Ms Gillian Dowds	**Date manager registered:** 24 July 2014
Categories of care: Nursing Homes (NH) DE – Dementia PH – Physical disability other than sensory impairment Residential Care Homes (RC) DE – Dementia LD – Learning disability MP(E) – Mental disorder excluding learning disability or dementia – over 65 years	**Number of registered places:** 43 comprising: • 39 nursing andfour residential • NH-PH - maximum of 10 patients • the home is also approved to provide care on a day basis to three persons.

4.0 Inspection summary

An unannounced inspection took place on 3 January 2018from 10.20 to 14.50.

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 term ‘patients’ is used to describe those living in Chester which,at this time,provides both nursing and residential care.

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 the governance arrangements for medicines, medicines administration and the management of controlled drugs.

One area for improvement was identified at this inspection in relation to record keeping.

Patients spoke positively about the management of their medicines and the care provided to them.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Ms Gillian Dowds, Registered 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 care inspection

Other than those actions detailed in the QIPno further actions were required to be taken following the most recent inspection on 20 April 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 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 inspectionwe met with fourpatients, four relatives,two registered nurses and the registered 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
- 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 20 April 2017

The most recent inspection of the home was an unannounced careinspection. 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 24 October 2016

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**: Regulation13(4) **Stated:** First time	The registered provider must review the record keeping regarding enteral feeding fluid intake charts to ensure that these are fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: Following the introduction of computerised records, staff had commenced recording fluid intake via the electronic system and this included details of 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.The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. A sample of records was made available. Refresher training in medicines managementwas provided in the last year. Training in the management of dysphagia and external preparations was planned for later this month.

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 and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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 robust 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.

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.

Largely satisfactory arrangements were observed for the management of high risk medicines e.g. anticoagulants. Written confirmation of the medicine regime was in place and a daily running stock balance was maintained. One recording error in the stock balance was noted and discussed.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal and two registered nurses were involved in the disposal of medicines. Staff were reminded that zopiclone is a Schedule 4 controlled drug and should be denatured prior to disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. The suitability of one medicine trolley in relation to replacement/repair was discussed and it was agreed that this would be followed up at the earliest opportunity. Medicine storage areas were tidy and 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 found throughout the inspection in relation to staff training, supervision and appraisal, the management of medicines on admission and medicines changes, and controlled drugs.

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 were satisfactory arrangements in place to alert staff of when time critical medicines must be administered, such as early morning medicines and also medicines which were prescribed at weekly, monthly and three monthly intervals.

The management of distressed reactions was reviewed. When a patient was prescribed a medicine for administration on a "when required" basis the dosage instructions were recorded on the personal medication record. Staff confirmed that they 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. Specific charts were used to record the reason for and the outcome of the administration of these medicines and included a running stock balance. This is good practice.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. A care plan was maintained.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 tell staff if they were experiencing pain, and confirmed that a pain assessment tool was used as needed. Staff also advised that a pain assessment was completed as part of the admission process.

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.

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 confirmed that most patients were compliant with their medicine regimes and provided evidence of the action taken following the ongoing non-administration of one medicine.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of separate administration records for transdermal patches and high risk medicines; and double signatures for the writing and updating of personal medication records and medication administration records. However, it was noted that some personal medication records required updating. Whilst it was acknowledged that these records were in the process of being printed as part of the new electronic system, these must be kept up to date and accurate at all times. An area for improvement was identified.

Practices for the management of medicines were audited on a daily and weekly basis by the staff and registered manager. This included running stock balances for some medicines which were not supplied in the monitored dosage system. Staff routinely recorded the stock balance of medicines carried forward to the next medicine cycle. These records readily facilitated the audit process and this good practice was acknowledged. A quarterly audit was also completed by the community pharmacist.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines and care planning. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The necessary arrangements should be made to ensure that personal medication records are kept up to date and accurate at all times.

	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 a small number of medicines was observed at the inspection. The patients were encouraged to take their medicines and these were administered in a kind and caring manner. The patients were given plenty of time to swallow 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; 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.

We noted good interactions between with the patients' relatives/visitors and it was evident from these that there was a good rapport between them.
The patients we met with spoke positively about their care and the management of their medicines. They were complimentary regarding staff and management. Comments included:
"I get on well and am happy."
"Staff are good."
"I couldn't complain about a thing."
"I love my food and the food here."

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.

The relatives we spoke with were complimentary about the care provided to their relative and raised no concerns.

Of the questionnaires which were left in the home to facilitate feedback from patients and their representatives, seven were returned. The responses indicated that they were very satisfied with all aspects of the care provided in the home. Two comments were also recorded:

"As a relative who is in Chester several times per week over the past 4 years I am very satisfied with the care my (relative)receives. The staff are all dedicated, and do a very good job under difficult circumstances. The manager (G Dowds) and asst nursing manager (B George) are excellent, and I have full confidence in their management."

"Staff are friendly and helpful. Some require more training and me more patience."

These comments were shared with the registered manager, who advised that in relation to training she had already organised further training for the staff. They were also shared with the care inspector.

No questionnaires were returned by staff within the specified timeframe (two weeks).

Areas of good practice

There were examples of good practice found throughout the inspection in relation to listening to and valuing patients and taking account of the views of patients and their relatives.

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 at this inspection. The registered manager advised that these were due for review in 2018. 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 robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how incidents were shared with them to inform learning and change of practice, if necessary. We were advised that incidents and audit outcomes were also discussed at supervision sessions or team meetings with staff. In relation to the regional safeguarding procedures, we were advised that staff were aware that medicine incidents may need to be reported to the safeguarding team.

A robust governance process to oversee medicines management was in place. A review of the audit records indicated that largely 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 registered manager and staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any medicines related concerns were raised with management. They advised that management were open and approachable and willing to listen. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

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 the QIP were discussed with Ms Gillian Dowds, Registered Manageras 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:** 3 February 2018	The registered person shall ensure that personal medication records are closely monitored to ensure these are kept up to date at all times. Ref: 6.5
	Response by registered persondetailing the actions taken: All medication records reviewed and updated where necessary and ongoing review of same and staff made aware of procedure for updatingon new system .Medicine records are updated as medicines are received into the home

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

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