Unannounced Medicines Management Inspection Report
5 February 2019

Chester

Type of Service: Nursing Home
Address: 27-29 Chester Avenue, Whitehead, BT38 9QQ
Tel No: 028 9335 3060
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 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 that provides care for up to 43 patients/residents living with care 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 Home (NH) DE – Dementia PH – Physical disability other than sensory impairment Residential Care Home (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 and four 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 5 February 2019 from 10.45 to 15.40.

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.

The term 'patient' is used to describe those living in Chester which provides both nursing and residential care.

Evidence of good practice was found in relation to training and competency assessment, the management of controlled drugs, care planning and the safe storage of medicines.

Areas for improvement were identified in relation to record keeping.

There was a warm and welcoming atmosphere in the home and the patients were observed to be relaxed and comfortable in their environment.

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	*2

*The total includes one area for improvement which has been stated for second time.

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. 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 17 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 was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with two care assistants, one registered nurse, the registered manager and the regional manager.

We provided 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA; we asked the registered 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 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 17 July 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was 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 3 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 ensure that personal medication records are closely monitored to ensure these are kept up to date at all times.	**Not met**
	Action taken as confirmed during the inspection: A review of the personal medication records indicated that a number of these were not up to date. See Section 6.5. This area for improvement was stated for a second time.	

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 or more frequently as required. A sample of records was provided. Refresher training in medicines management was provided in the last year.

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. Written confirmation of medicine regimes and any medicine changes was obtained. Personal medication records were updated by two trained staff. This is safe practice and was acknowledged. However, handwritten entries on the medication administration records (MARs) were not updated by two trained staff. An area for improvement in relation to these records was made in Section 6.5.

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.

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 annually.

The management of controlled drugs was reviewed. 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 performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. injectable medicines including insulin. Care plans were maintained.

Discontinued or expired medicines including controlled drugs were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised and patients' medicines were clearly segregated. There were satisfactory systems to manage medicines which required cold storage and medicines with a limited shelf life once opened. Oxygen equipment was checked on a regular basis.

Areas of good practice

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

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. A few discrepancies were observed for close monitoring and this was being implemented during the inspection.

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 mid weekly, weekly or three monthly medicines were due.

The management of pain was reviewed. Medicine details were recorded on the personal medication records. Care plans and pain assessments were maintained. Analgesic administration records were in use to enable staff to record the reason for any administration.

In the instances where patients were prescribed medicines to manage distressed reactions, the relevant records and care plans were maintained. Staff advised they were aware that the changes in behaviour may be due to pain and advised pain management would be considered at the time.

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. Records of administration, care plans and speech and language assessment reports were in place.

Staff advised 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 patient's family and prescriber. There were examples of when this had occurred and had resulted in changing the formulation of the medicine to promote patient compliance.

Some of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate administration records for transdermal patches and analgesics/benzodiazepines administered on a "when required" basis. In relation to personal medication records we noted that several changes in medicines had not been recorded on these records; however, were recorded on the MARs and the area for improvement in Section 6.2 was stated for a second time. A review of the MARs indicated that handwritten entries were not always checked by two staff, the start date was missing for some records and the reason for the use of one code regarding administration was not explained. See also Section 6.4. An area for improvement was made.

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

Following discussion with the staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs. Examples of this in relation to dietary needs, infection and pain management were provided. Management also advised of the recent implementation of weekly general practitioner visits and review of patients' medicines.

Areas of good practice

There were examples of good practice in relation to care planning and the administration of medicines.

Areas for improvement

One area for improvement in relation to personal medication records has been stated for a second time.

The completion of MARs should be closely monitored to ensure these are fully and accurately maintained.

	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 during the inspection. The registered nurse explained the medicines to the patients and encouraged compliance, giving the patients time to take their medicines.

Following discussion with staff it was evident they were knowledgeable about the patients' medicines and how the patients preferred to take their medicines.

Throughout the inspection, it was found that there were good relationships between the staff, the patients and the patients' representatives. Staff were noted to be friendly and courteous and engaged with the patients; they treated the patients with dignity. It was clear from observation of staff, that they were familiar with the patients' likes and dislikes.

There was a warm and welcoming atmosphere in the home. The patients were observed to be relaxed and comfortable in the lounge areas. We noted that some patients were singing and listening to music in the morning.

In relation to lunch, we heard patients comments which were "That was a lovely lunch." and "The food is very nice indeed." In the afternoon some patients were enjoying pet therapy.

Of the questionnaires which were left for patients/patients' representatives, five were returned within the specified time frame (two weeks). The responses were recorded as "very satisfied" with the care provided. Two comments were made:

- "I visit xxx(patient) most days and I find Chester provides a very safe and happy home. The staff are good, attentive and well managed. Activities are frequent and I believe that my xxx condition has improved - awareness and mobility."

- "All staff are very caring and excellent at their jobs. 1st class care."

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

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.

We discussed the 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. We were advised that there were arrangements in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. These were not examined. Staff advised that there were procedures in place to ensure that they were made aware of any changes.

The governance arrangements for medicines management were examined. There was evidence of auditing and monitoring systems, including support from the community pharmacist. We were advised of the daily, weekly and monthly audits completed and how areas for improvement were shared with staff to address. This was usually through team meetings and supervision/staff memos. A sample of audit records was made available at the inspection. As one area for improvement has been stated again, the registered manager advised that a staff meeting would be held to reiterate the need for accurate records.

There were satisfactory arrangements in place for the management of medicine related incidents. Staff knew how to identify and report incidents, including referral to the safeguarding team as necessary. We were provided with details of the procedures in place, to ensure that all staff were made aware of incidents and the systems to prevent recurrence.

Staff confirmed that there were effective communication systems to ensure that they were kept up to date. They advised there was a detailed handover which was written and verbal; and in relation to medicines management, this included swallowing difficulty, antibiotics and medical conditions e.g. diabetes. A communications book was also in use.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns were raised with management.

The staff spoke positively about their work and advised there were good working relationships in the home and with other healthcare professionals. They stated they felt well supported in their work and were complimentary regarding the management team, training and development. 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 some 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 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 29 **Stated:** Second time **To be completed by:** 7 March 2019	The registered person shall ensure that personal medication records are closely monitored to ensure these are kept up to date at all times. Ref: 6.2 & 6.5
	Response by registered person detailing the actions taken: Following a staff meeting and individual discussions with nursing staff it was decided that each primary nurse will ensure to include medicine kardexes as part of the monthly evaluation of client care. Each nurse will also be responsible to ensure that the records are updated on receiving new items and written up on records accurately and checked/signed by 2 staff. The manager will also perform random audits of medicine records.
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 7 March 2019	The registered person shall ensure that medication administration records are fully and accurately maintained as detailed in the report. Ref: 6.4 & 6.5
	Response by registered person detailing the actions taken: All medicine records were checked and adjusted where needed, and all staff informed via meeting and individual discussion of their role and responsibilities in maintaining the records and actions required to ensure same.

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

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