Unannounced Medicines Management Inspection Report
31 May 2018

The Model Care Home

Type of Service: Nursing Home
Address: 1 Portrush Road, Ballymoney, BT53 6BX
Tel No: 028 2766 4502
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 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 which is registered to provide care for up to 36 patients.

3.0 Service details

Organisation/Registered Provider: Four Seasons (No. 11) Limited **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Mr Vasco Alves
Person in charge at the time of inspection: Mr Bogdad Chitac (Staff Nurse)	**Date manager registered:** 14 April 2017
Categories of care: Nursing Homes (NH): I – Old age not falling within any other category	**Number of registered places:** 36

4.0 Inspection summary

An unannounced inspection took place on 31 May 2018 from 10.35 to 14.10.

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 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, training, the completion of most records, the administration of medicines, the management of controlled drugs and the storage of medicines.

No areas for improvement were identified.

Patients said they were happy in the home and spoke positively about the management of their medicines and the care provided by staff. We noted the warm and welcoming atmosphere 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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Joana Silva, Acting Sister, as part of the inspection process and can be found in the main body of the report.

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 6 February 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 two patients, two registered nurses, one care assistant, the housekeeper, the activities co-ordinator and the acting sister. We also met briefly with a registered manager from another care home within this organisation.

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
- policies and procedures
- care plans
- medicines storage temperatures

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 6 February 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 25 January 2017

There were no areas for improvement identified as a result of the last medicines management inspection.

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 process was in place to ensure that all staff were kept up to date with training in medicines management. 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 each 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 medicines changes. Written confirmation of medicine regimes and new medicine dosages was in place. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

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.

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.

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

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 largely satisfactory systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The date of opening was not recorded on all insulin pens in current use; a review of the dosage regimes indicated that these would require replacement before the 28 day expiry date was reached. It was agreed that this would be raised with staff. 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 changes, controlled drugs 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 prescribers' instructions.

There was evidence that bisphosphonate medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of medicines administered at weekly, monthly and three monthly intervals were due. Reminders were marked out on the medication administration records.

The management of distressed reactions was reviewed. 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. Most of the records were well maintained and included the necessary information. In relation to one patient, the care plan needed updating and the reason for and outcome of the administration were not always recorded. Staff advised that this had been an oversight and detailed the expected practice. We were provided with assurances that the care plan would be updated and a new record to assist staff in recording the details of administration would be implemented by the end of the day.

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 assessment tool was used as needed. A care plan was maintained.

The management of swallowing difficulty for two patients was examined. The 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.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for transdermal patches and high risk medicines and protocols for 'when required' medicines such as analgesics and laxatives.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several oral and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

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

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible. The registered nurse explained the medicine and encouraged the patient to take 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 they were familiar with the patients' likes and dislikes.

We met with two patients, who expressed their satisfaction with the staff and the care provided. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were adhered to. They stated they had no concerns. Comments included:

"They (staff) are very good, they are gentle with me."
"They (staff) couldn't do enough for you."
"I am happy here."
"They offer me other food if I want it."

Of the questionnaires which were left in the home to facilitate feedback from patients and their representatives, none were returned within the time frame (two weeks). 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 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.

The inspector 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. We were advised that there were arrangements in place to implement the collection of equality data within The Model Care Home.

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

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 provided details of the procedures in place to ensure that all staff were made aware of incidents and to prevent recurrence. They also advised that as part of their ongoing quality improvement, issues raised in other homes within the organisation were shared with them and vice versa. 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 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 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 the registered manager; and any resultant action was discussed at team meetings and/or supervision.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. They stated they felt well supported in their work and some advised us they had worked in the home for several years. Comments included:

“The manager is brilliant, he is so hands on.”
“We have a great team here.”
“I love my job; I don’t want to work anywhere else.”

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date. The shift handovers were verbal and written and a specific communication book for care staff was in place.

There were no online questionnaires completed by staff with 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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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