Unannounced Medicines Management Inspection Report
10 April 2018

Galgorm

Type of Service: Nursing Home
Address: 90 Galgorm Road, Ballymena, BT42 1AA
Tel No: 028 2565 1365
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 with 35 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: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Mrs Lisa McDonald
Person in charge at the time of inspection: Mrs Lisa McDonald	**Date manager registered:** 16 January 2015
Categories of care: Nursing Homes (NH): 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 TI – Terminally ill	**Number of registered places:** 35 including: - NH-TI – a maximum of three patients - a maximum of five named persons receiving residential care in category RC-I

4.0 Inspection summary

An unannounced inspection took place on 10 April 2018 from 10.10 to 14.40.

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.

Evidence of good practice was found in relation to the governance arrangements, training and competency assessment, administration of medicines, medicine storage and controlled drugs.

Areas requiring improvement were identified in relation to the completion of medicine records.

Patients were noted to be relaxed and comfortable in their surroundings and in their interactions with staff. The patients we met with spoke positively about their care and their well-being. 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	*2

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Lisa McDonald, Registered Manager and Mrs Louisa Rea, Regional Manager, Four Seasons Health Care, 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 29 August 2017 and 6 September 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 was displayed to inform visitors to the home that an inspection was being conducted.

During the inspection we met with two patients, two registered nurses, the registered manager and the regional manager.

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

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.

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 29 August 2017

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 2 May 2017

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 29

Stated: First time</td><td>The registered provider should ensure that two trained staff are involved in transcribing medicines information onto personal medication records and medication administration records; both staff should initial the entry.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was little evidence that two staff were routinely involved in the transcribing of medicine details onto medicine records.

This area for improvement was stated for a second time.</td></tr>
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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 following induction and annually thereafter. A process was in place to ensure that all staff completed refresher training in medicines management. Other training included the management of dysphagia and dementia. 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 and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home. Written confirmation of the medicines regime was obtained at or prior to admission. However, in relation to the writing of personal medication records at the time of admission, or medicine changes, it was noted that this did not always involve two staff. This should occur to ensure accuracy of the medicines information. This issue was raised at the previous inspection and the area for improvement has been stated for a second time.

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. insulin. Written confirmation of dosage regimes was in place and care plans were maintained.

Epilepsy management plans were in place for medicines which were required to be administered in the event of seizures.

The management of administering medicines in disguised form was examined. A care plan was maintained and consent had been obtained from the prescriber.

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 good practice of recording the date of expiry on eye preparations was acknowledged. 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, medicine storage 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.

With the exception of a few medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. These medicines were highlighted to staff and management. We were assured that these medicines would be closely monitored within the audit process.

For one eye preparation, it could not be confirmed if this medicine had been administered in the last nine days. This was highlighted to staff, who referred this to a designated healthcare professional during the inspection. Management gave assurances that this would be reviewed with staff with immediate effect.

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. Reminder alerts were in place on the medicine administration records.

The management of pain and distressed reactions were reviewed. Care plans were in place and included as applicable, protocols for "when required" medicines and records to detail the reason for and the outcome of administration. This is good practice.

The management of swallowing difficulty was examined. The details were recorded on the patient's personal medication records and care plans. It was noted that one patient's care plan did not reflect a recent change in the speech and language assessment report. This was addressed at the inspection. Following discussion with staff and a review of the fluid charts, it was concluded that the correct fluid consistency was being administered to the patient and that they were aware of the recent changes. It was agreed that this would be closely monitored as part of the audit 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.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for high risk medicines and transdermal patches. However, in relation to personal medication records, a number of these were not up to date and the potential risk was discussed. An area for improvement was identified. As part of the overall discussion, staff were reminded that entries in medicine records must not be amended and there should be no overwriting. Management agreed to raise this with all relevant staff.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines which were not contained within the 28 day blister packs and also the stock balance of some medicines carried forward to the next medicine cycle. This good practice was acknowledged. In addition, a quarterly audit was completed by the community pharmacist.

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

Areas of good practice

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

Areas for improvement

The necessary arrangements should be made to ensure that personal mediation records are kept up to date 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 medicines to patients was not observed during this inspection. Following discussion with staff it was confirmed that patients were given time to take their medicines and medicines were given in accordance with the patients' preferences.

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 care, the staff and the registered manager. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were adhered to. Comments included:

"I am getting on well."
"The staff are good."
"I don't have any concerns."
"The food is good and there is plenty of it."

Of the questionnaires which were left in the home to receive feedback from patients and their representatives, none were returned with the specified time frame (two weeks). Any comments from patients and their representatives in returned questionnaires received after the return date, will be shared with the registered manager for their information and action as required.

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. The registered manager confirmed there were arrangements in place to implement the collection of equality data within Galgorm.

Written policies and procedures for the management of medicines were in place. These were not examined. Staff confirmed that these were readily available for reference.

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 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 registered nurses, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

There were effective communications systems in the home to ensure that all staff were kept up to date. The shift handovers were verbal and written and a sample of the written handover sheet was observed. In relation to medicines management, the handover sheets included e.g. the commencement of antibiotics.

The area for improvement made at the last medicines management inspection had not been addressed effectively. To ensure that this is fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated through team meetings, supervision or individually with staff. They advised that management were open and approachable and willing to listen; and stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

No online questionnaires were completed by staff within 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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Lisa McDonald, Registered Manager and Mrs Louisa Rea, Regional 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:** 10 May 2018	The registered provider should ensure that two trained staff are involved in transcribing medicines information onto personal medication records and medication administration records; both staff should initial the entry. Ref: 6.2 & 6.4
	Response by registered person detailing the actions taken: All registered nurses have received clinical supervision on ensuring two trained staff are responsible for transcribing medicines information. The topic was discussed and reiterated at our quarterly Clinical Governance meeting also. Home Manager will monitor and oversee each month on completion of HM monthly medication audit.
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 10 May 2018	The registered person shall make the necessary arrangements to ensure that personal medication records are kept up to date at all times. Ref: 6.5
	Response by registered person detailing the actions taken: All personal medication records are now checked at the beginning of each new four weekly cycle. The personal medication records have been divided into groups and allocated to a nurse on each shift prior to the new cycle starting to ensure all resident's records are captured monthly. Home Manager will monitor and oversee each month on

	completion of the HM monthly medication audit.

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

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