Unannounced Medicines Management Inspection Report
31 October 2018

Antrim Care Home

Type of Service: Nursing Home
Address: 88 Milltown Road, Antrim, BT41 2JJ
Tel No: 028 9442 8717
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 51 beds that provides care for patients living with healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Hutchinson Homes Ltd **Responsible Individual:** Mrs Janet Montgomery	**Registered Manager:** Mrs Sharon Smyth
Person in charge at the time of inspection: Mrs Sharon Smyth	**Date manager registered:** 10 June 2016
Categories of care: Nursing Homes (NH): DE - Dementia 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:** 51

4.0 Inspection summary

An unannounced inspection took place on 31 October 2018 from 10.05 to 17.15.

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 training and competency assessment, the management of new medicines and medicine changes and the administration of medicines.

Areas for improvement were identified in relation to the management of controlled drugs, care planning, records of administration and infection prevention and control.

The patients and patient representatives we met with spoke positively about the staff and the care provided. 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	*1	5

*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 Sharon Smyth, 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 6 August 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; there had been none 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 four patients, five patient representatives, three registered nurses, one care assistant, the community pharmacist and the registered manager.

We provided 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA and 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 received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures

We provided 'Have we missed you?' cards 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 6 August 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 5 October 2017

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 30 **Stated:** Second time	The registered provider should ensure there is a robust system in place for the management of limited shelf-life medicines.	**Met**
	Action taken as confirmed during the inspection: There were systems in place to ensure that limited shelf life medicines were not used after the in use expiry date was reached.	

Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall closely monitor the administration of inhaled medicines to ensure that these are administered as prescribed.	**Met**
	Action taken as confirmed during the inspection: These medicines were included in the audit process. No further concerns regarding the administration of inhaled medicines were observed.	
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time	The registered person shall review the management of distressed reactions to ensure that a detailed care plan is in place for each patient and the outcome of administration is recorded.	**Partially met**
	Action taken as confirmed during the inspection: We reviewed the records for five patients. Care plans were in place for three of the patients; and for one of these patients who was prescribed two medicines, the care plan did not indicate the parameters for administration. The reason for and outcome of administration were recorded for four patients. This area for improvement is stated for a second time.	
Area for improvement 4 **Ref**: Standard 4 **Stated:** First time	The registered person shall review the management of pain to ensure that pain assessments are completed and a record maintained; pain management is referenced in a care plan and further guidance is provided for pain management in dementia.	**Partially met**
	Action taken as confirmed during the inspection: Staff had been provided with dementia training including pain management. Specific records were in place to record the reason for and outcome of analgesia. Care plans and pain assessments were in place for most but not all of the patients' records examined. These were not in place for some patients receiving intermediate care. This has been subsumed into specific area for improvement regarding care planning. See Section 6.5.	

Area for improvement 5 **Ref**: Standard 29 **Stated:** First time	The registered person shall review the management of external preparations to ensure robust systems are in place.	**Met**
	Action taken as confirmed during the inspection: External preparations are audited on a weekly basis by registered nurses. With the exception of one external preparation, records of administration were well maintained. This was discussed with staff and due to the assurances given, this area for improvement was assessed as met.	

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. Staff competency assessments were completed following induction, at least annually or more frequently as required. The registered manager advised that the impact of training was monitored through team meetings, regular supervision and annual appraisal. Refresher training in medicines management was provided annually. The most recent training was in relation to anaphylaxis and the revised terminology regarding the management of swallowing difficulties.

There were largely satisfactory 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 were obtained. Personal medication records were updated by two trained staff. This is safe practice and was acknowledged. However, we noted one patient's prescribed nutritional supplement had not been supplied at the time of admission and had not been noted by staff. This resulted in the patient missing several doses. This was brought to the registered manager's attention and reported to the relevant persons with immediate effect. The registered manager provided details of the corrective action taken.

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, report and follow up 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 had been completed.

The management of controlled drugs was reviewed. We observed that improvements were required in the completion of controlled drug record books and disposal. Whilst there were systems in place to record the receipt and administration of controlled drugs, there were several incomplete entries regarding disposal, i.e. the record stated there should be stock, but the stock was no longer held in the home. We were unable to correlate the entries with the disposal/transfer records examined at the inspection. The need to ensure that disposal/ transfer records are accurately maintained was highlighted. The registered manager was requested to investigate these observations and provide a written report to RQIA. A satisfactory response was provided on 5 November 2018. It was also noted that the disposal kits for controlled drugs were not being used correctly. An area for improvement was made.

Largely satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. Care plans were maintained. Written confirmation of doses was obtained. A separate administration record was in use for warfarin which included running stock balances. In relation to insulin, whilst administration was recorded on the general medication administration records, a separate insulin administration chart which clearly shows the number of units per type of insulin and site of administration was not in use. As this is a high risk medicine, this is considered best practice and had been discussed at the last medicines management inspection. An area for improvement was made.

Appropriate arrangements were in place for administering medicines in disguised form. A care plan was maintained.

At the care inspection, an area for improvement in relation to medicines storage had been made. We reviewed medicine storage and noted that medicines were stored safely and securely and in accordance with the manufacturer's instructions. The 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 and for the cold storage of medicines

The management of oxygen was reviewed. Systems were in place to monitor stock levels and equipment on a regular basis. Staff were reminded that the oxygen cylinders in one treatment room should be chained to the wall; a chain was available and it was agreed this would be addressed with immediate effect. At the care inspection, an area for improvement was made in in relation to oxygen signage; we observed that this was appropriately displayed.

With the exception of controlled drugs as mentioned above, discontinued or expired medicines were disposed of appropriately.

In relation to infection control, we noted that several sharps containers were in use, they were not marked with the date of opening and some of these were open at all times. An area for improvement was identified.

Areas of good practice

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

Areas for improvement

Robust arrangements must be put in place for the management of controlled drugs.

An insulin administration chart should be implemented.

In relation to infection control, the management of sharps containers should be closely monitored within the home's audit process.

	Regulations	Standards
Total number of areas for improvement	1	2

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. We were unable to complete the audit on one patient's medicines, as a record of incoming medicines had not been maintained. This was discussed with the registered manager for her attention and follow up.

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 management of pain and distressed reactions was reviewed. See also Section 6.2. We noted that in addition to night sedation, one patient had been administered a "when required" medicine at the same time to manage distressed reactions. Both medicines had been recently prescribed. This was discussed and it was agreed that the prescriber would be contacted for advice.

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 prescriber.

As part of the inspection process, we reviewed a number of care plans. For patients accommodated in the home on a permanent basis, these were well maintained. However, for patients receiving intermediate care, detailed care plans were not in place. Care plans should be developed within five days of a patient's admission to the home. We discussed this with the registered manager and nurse at the inspection and we were assured that these care plans would be written by the deputy manager by 2 November 2018. A similar issue had also been identified at the most recent care inspection and an area for improvement identified. A system should be developed to ensure that all care plans are in place. An area for improvement was identified.

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. Speech and language assessment reports were in place. Registered nurses and care staff were responsible for administration. A review of the records completed by care staff indicated that the consistency of the fluid and a signature from the staff member were not recorded. An area for improvement was identified. The registered manager advised that a new template to record this was under consideration and advice was given.

Most of the medicine records were well maintained and facilitated the audit process. See also Section 6.4 regarding controlled drugs records. Areas of good practice were acknowledged. They included the separate administration records for "when required" medicines, transdermal patches and three monthly injections. Staff were reminded that obsolete personal medication records and warfarin dosage regimes should be removed from the current folder(s) and archived.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines. 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. We were provided with examples of this in relation to changes in a patient's behaviour and podiatry.

Areas of good practice

There were some examples of good practice in relation to the standard of record keeping and the administration of medicines.

Areas for improvement

A system should be developed to ensure that care plans are developed in a timely manner.

The area for improvement identified at the last medicines management inspection in relation to distressed reactions has been stated for a second time.

The completion of records regarding the administration of thickening agents should be reviewed.

	Regulations	Standards
Total number of areas for improvement	0	2

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 carried out in a kind and caring manner. The registered nurse spoke discreetly to patients and encouraged them 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 friendly and courteous; they treated the patients with dignity. From observation of staff and discussion with patients/ representatives, it was clear that staff were familiar with the patients' likes and dislikes.

We noted the warm and welcoming atmosphere in the home. Hallowe'en decorations were displayed.

We met with four patients who were complimentary regarding their experience in the home, the staff and the care provided. They stated that staff listened to them, any requests e.g. for pain relief were met and that they had no concerns. Comments included:

- "I am far safer here than at home."
- "Staff are lovely. They are more than good to me."
- "They (staff) couldn't look after me any better."
- "The food here is lovely."
- "There is always someone to look after you."
- "The staff are kind and friendly."

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.

We also met with five patients' representatives. All spoke positively about the staff, the patient's treatment and care in the home. Comments included:

- "The care is really good."
- "They (staff) keep us informed."
- "Xxx (patient) is looked after well, no complaints at all."
- "My xxx (patient) is doing well in this home."
- "This home is one of the best care homes we've been in."

In addition to these comments, one relative raised some concerns regarding laundry and with their consent this was raised with the registered manager for her attention and also with the care inspector.

Of the questionnaires which were left in the home, none were returned with the specified time frame (two weeks). Any comments received in questionnaires received after the return date will be shared with the registered manager as required.

Areas of good practice

Staff listened to patients and their representatives 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 there were arrangements in place to implement the collection of equality data within Antrim Care Home.

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.

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. They provided details of the procedures in place to ensure that all staff were made aware of incidents and the systems to prevent recurrence.

The governance arrangements for medicines management were examined. We were advised of the auditing processes completed and how areas for improvement were shared with staff to address and of the systems to monitor improvement.

Staff advised that there were effective communication systems to ensure that all staff were kept up to date. As part of the shift handover, a written patient report was used and this included reference to medicines management.

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 in relation to medicines management were raised with the 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 and the training provided.

No online questionnaires were 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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Sharon Smyth, 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 30 November 2018	The registered person shall develop robust systems for the management of controlled drugs. Ref: 6.4
	Response by registered person detailing the actions taken: This has been discussed in supervision with all staff and following their annual medicine competency reviews. Audit processes have also been updated
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 18 **Stated:** Second time **To be completed by:** 30 November 2018	The registered person shall review the management of distressed reactions to ensure that a detailed care plan is in place for each patient and the outcome of administration is recorded. Ref: 6.2 and 6.5
	Response by registered person detailing the actions taken: All care plans have been updated. Managers audit will monitor new clients as they are admitted, and relevant care plans put in place
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 30 November 2018	The registered person shall implement the use of insulin administration charts. Ref: 6.4
	Response by registered person detailing the actions taken: This has been implemented.
Area for improvement 3 **Ref**: Standard 46 **Stated:** First time **To be completed by:** 30 November 2018	The registered person shall closely monitor the management of sharps containers in relation to infection control. Ref: 6.4
	Response by registered person detailing the actions taken: All staff have been made aware to record the date of opening on sharps boxes and ensure they are collected when filled.

Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 30 November 2018	The registered person shall develop a system which ensures that detailed care plans are developed in a timely manner. Ref: 6.5
	Response by registered person detailing the actions taken: The named nurse system has been updated to accomodate new staff and ensure all care plans are completed within 5 days od admission. Audits will continue to monitor this
Area for improvement 5 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 30 November 2018	The registered person shall review and monitor the recording procedures for thickened fluids administered by care staff. Ref: 6.5
	Response by registered person detailing the actions taken: Paperwork has been updated to ensure staff are recording thicheners accurately

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews