Unannounced Medicines Management Inspection Report
14 June 2018

Fairfields Care Centre

Type of Service: Nursing Home
Address: 80a Fair Hill Road, Cookstown, BT80 8DE
Tel No: 028 8676 6294
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 70 beds that provides care for patients living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Care Facilities & Management Ltd **Responsible Individual:** Mrs Barbara Haughey	**Registered Manager:** Mr Phillip McGowan
Person in charge at the time of inspection: Ms Miriam Smith (Deputy Manager) until 11.45 and Mr Phillip McGowan thereafter	**Date manager registered:** 18 April 2016
Categories of care: Nursing Homes (NH): I - Old age not falling within any other category DE - Dementia LD(E) - Learning disability – over 65 years MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH - Physical disability other than sensory impairment	**Number of registered places:** 70 including: NH-DE - a maximum of 28 patients NH-I/NH-PH - a maximum of 33 patients NH-MP(E) - no more than one patient NH-LD(E) - one identified patient only the home is also approved to provide care on a day basis for five persons there shall be a maximum of three named residents receiving residential care in category RC-I

4.0 Inspection summary

An unannounced inspection took place on 14 June 2018 from 10.30 to 16.20.

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, competency assessment, the administration of most medicines, medicines storage, the standard of record keeping and the management of controlled drugs.

One area for improvement was identified in relation to the administration of medicines.

Patients and a relative spoke positively about the staff and the care in the home. The patients were noted to be relaxed and comfortable in their surroundings and interactions with staff.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Mr Phillip McGowan, 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 premises inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 15 May 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 four patients, one relative, three registered nurses, two deputy managers 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 received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

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 15 May 2018

The most recent inspection of the home was an unannounced premises inspection. The completed QIP will be reviewed by the estates inspector and will be validated at the next premises inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 19 September 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: Second time</td><td>The registered provider should implement a robust system to monitor the administration records regarding external preparations.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The management of external preparations had been reviewed and new systems developed for recording administration and auditing. A specific recording system for care staff was also in place. With the exception of records for one patient, these records were well maintained. The registered manager gave assurances that this would be addressed and the audit process further developed. Given these assurances this area for improvement has been assessed as met.</td></tr>
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Area for improvement 2 **Ref:** Standard 29 **Stated:** First time	The registered person shall develop a system to ensure that personal medication records are kept up to date and accurate.	**Met**
	Action taken as confirmed during the inspection: The personal medication records examined at the inspection were well maintained. Some were handwritten and others were printed. We were informed that as part of the ongoing quality improvement, all of these records would be printed.	
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time	The registered person shall review the storage of medicines to ensure safe systems are in place.	**Met**
	Action taken as confirmed during the inspection: There was evidence that medicines were stored safely and securely. Medicines were clearly segregated per patient on the medicine trolleys and in the overstock cupboards.	

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 new system to record staff supervision and staff competency had been developed and implemented. A sample of records was provided. Medicines management training had been provided following the introduction of a new medicine system at the start of the year. Training on the management of swallowing difficulty was planned.

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.

The stock control of medicines was reviewed. Management and staff advised of the ordering process to ensure that medicines were available for administration and of the follow up process to obtain any medicines which had not been received. 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.

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.

Appropriate arrangements were in place to manage any medicines which were required to be crushed prior to administration and/or administered in disguised form.

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. Medicine refrigerators 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 medicine changes, controlled drugs and medicines storage.

Areas for improvement

No areas for improvement were identified at 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.

There was evidence that the new medicine system was well established. Staff confirmed that it worked well and this correlated with the inspection outcomes.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. See also Section 6.4. We noted that two medicines (one eye preparation and one tablet) had been omitted for four doses and five doses; the reason could not be clarified at the inspection. An area for improvement was identified.

There was evidence that time critical medicines had been administered at the correct time. Arrangements were in place to alert staff of when doses of weekly or three monthly medicines were due.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Care plans were maintained. 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. The reason for and the outcome of administration were recorded on most occasions. This should be recorded on all occasions and staff confirmed it was the expected practice. Staff advised that a separate administration record to assist with this would be put in place. One patient required regular administration; staff and management confirmed that the patient's prescriber and family had been informed. The need to ensure that this detail was recorded in the care notes was discussed. We were assured that this would be added to the care notes with immediate effect.

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 they were familiar with how the patients would communicate pain and stated that most of the patients could verbalise any pain. A pain assessment tool was available for use 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. 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 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 the separate administration records for transdermal patches.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for the majority of medicines, including solid dosage medicines, sachets and inhaled medicines and also maintaining a record of the stock balance carried forward to the next medicine cycle. These areas of good practice were acknowledged. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with management 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. They provided examples of when this had occurred in relation to skincare.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of most medicines.

Areas for improvement

The non-administration of two medicines should be reviewed to ensure that these are administered as prescribed; a report of the findings and action taken should be forwarded to RQIA.

	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 at this inspection. Following discussion with staff it was evident that patients were administered their medicines in a caring manner and were given time to take their medicines.

Throughout the inspection, it was found that there were good relationships between the staff, the patients and their representatives. 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 four patients, who expressed their satisfaction with the care provided and the staff. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were responded to and stated that they had no concerns. Comments included:

"The staff are very good, they'll come to help you."
"This home is much better than where I was before; I can do more things here."
"I'm getting on alright."
"The food is good, I eat most things and if not I get something else."
"I have no complaints."
"I am being looked after."

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 one relative who spoke very positively about some elements of the care in the home; however, advised she had a few concerns but stated she did not want to raise them with the registered manager or staff. This was discussed with the relative and advice given. We also gave the relative a copy of RQIAs "How can I raise concern…" leaflet. At the end of the inspection, we informed the registered manager that one relative had some concerns and that we had encouraged her to bring them to his attention to address.

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 questionnaires received after the return date will be shared with the registered manager for information and action as required.

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.

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 Fairfields Care Centre.

The management of medicine related incidents was examined. There were systems in place to escalate identified medicine incidents to management. Staff confirmed that they knew how to identify and report incidents and advised of the procedures in place to ensure that all staff were made aware and to prevent recurrence. The medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken, which had included an increase in the frequency of audits and development of new systems; and also that these were reported to the safeguarding team as necessary.

The governance arrangements for medicines management were reviewed. Staff and management advised of the daily, weekly and monthly audits which now take place and how areas for improvement were identified and followed up. We were provided with a sample of the action plans which were developed as part of the new monitoring systems for medicines management.

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 concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff individually, at team meetings or supervision.

The staff we met with spoke positively about the home, how they enjoyed the team work, the training opportunities and the good working relationships in the home and with other healthcare professionals. They were complimentary about the management team.

No online questionnaires were completed by the 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 Mr Phillip McGowan, 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 28 **Stated:** First time	The registered person shall review the non-administration of two identified medicines; a report of the findings and action should be forwarded to RQIA. Ref: 6.5
To be completed by: 14 July 2018	**Response by registered person detailing the actions taken:** Findings have been sent to the RQIA on the 16th July 2018. Actions required will be reviewed and updated on the next PIC visit

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

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