Unannounced Medicines Management Inspection Report
1 June 2017

Hockley Private Nursing Home

Type of Service: Nursing Home
Address: 11 Drumilly Road, Armagh, BT61 8RG
Tel no: 028 3887 0365
Inspector: Helen Daly

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 60 beds that provides both nursing and residential care.

3.0 Service details

Organisation/Registered Provider: Elim Trust Corporation **Responsible Individual:** Pastor Edwin Michael	**Registered Manager:** See below
Person in charge at the time of inspection: Ms Mary Jane Sagayno	**Date manager registered:** Ms Mary Jane Sagayno – awaiting application-registration pending
Categories of care: Nursing Care (NH): I- nursing, old age not falling within any other category Residential Care (RC): I - residential, old age not falling within any other category	**Number of registered places:** 60 Fifty-six nursing; four residential. There shall be a maximum of 32 patients accommodated in the Mews Wing and a maximum of 28 patients accommodated within the Lodge Wing.

4.0 Inspection summary

An unannounced inspection took place on 1 June 2017 from 10.35 to 14.40.

This inspection was underpinned by 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 term ‘patients’ is used to describe those living in Hockley Private Nursing Home which provides both nursing and residential care.

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 medicines administration, medicine records, storage and the management of controlled drugs.

One area for improvement was identified in relation to the management of out of stock medicines.

Relatives and patients were complimentary regarding the care provided by staff 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	1	0

Details of the Quality Improvement Plan (QIP) were discussed with Ms Mary Jane Sagayno, Manager, and members of the management team, 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 8 December 2016.

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 the inspector met with two patients, two relatives, one care assistant, one kitchen assistant, five registered nurses, the deputy manager and the manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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

Areas for improvements 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 8 December 2016

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 18 July 2016

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 ambient temperature of the treatment rooms should be monitored and recorded each day to ensure they do not exceed 25 ^{o}C.	**Met**
	Action taken as confirmed during the inspection: The temperatures of the treatment rooms were being monitored and recorded each day in both units. The temperatures were below 25 ^{o}C.	
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time	The registered provider should review the management of delegated tasks as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: Care assistants were no longer administering prescription only external medicines. Records for the administration of emollient preparations and thickening agents by care assistants had been maintained in a satisfactory manner.	

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 assistants who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Training was discussed with three recently recruited registered nurses who advised that they had completed e-learning and had received supervision on medicines management.

A review of the care records, personal medication records and medication administration records evidenced that antibiotics and newly prescribed medicines were received into the home without delay.

Three medicines had been out of stock in the Mews unit recently. Two of these out of stocks had been investigated and followed up; the medicines were available on the day of the inspection. Registered nurses had taken appropriate and prompt action. However, the third medicine had been out of stock for six days and was not available on the day of the inspection. There was no evidence of the action taken to obtain this medicine. The manager was requested to contact the prescriber for guidance without delay. The registered person must ensure that medicine doses are not omitted due to being out of stock. An area for improvement was identified.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged. Obsolete personal medication records had been cancelled and archived.

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 and was ongoing.

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. The use of separate administration charts was acknowledged. Registered nurses were reminded that insulin dosage directions should not be abbreviated.

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. It was agreed that inhaler spacer devices would be cleaned/replaced at regular intervals.

Areas of good practice

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

Areas for improvement

The registered person must ensure that medicine doses are not omitted due to being out of stock.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The audits completed at this inspection indicated that medicines had been administered as prescribed. 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, monthly 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 records. Care plans were in place. 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. For two patients the medicines were being administered each morning; it was agreed that this would be reviewed with the prescribers.

The management of pain was reviewed for two patients. Care plans were in place. The 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 patients were comfortable. Staff advised that most of the patients could verbalise any pain, and a pain assessment tool was used as needed.

The management of swallowing difficulty was reviewed. Care plans and speech and language assessment reports were in place. Details of the required consistency were recorded on the personal medication records and records of administration.

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. Registered nurses were reminded that the allergy status of each patient should be recorded on the personal medication records.

Practices for the management of medicines were audited throughout the month by the staff and management.

Following discussion with the registered nurses, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

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.

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.

We observed the administration of medicines to patients at lunchtime. Patients were given time to take their medicines and were being offered pain relief.

Patients were observed to be relaxed and enjoying their lunch.

We spoke with two patients who advised that they were very happy with the care provided in the home. Both patients said that they were never in pain. They were complimentary of the staff and food.

Two relatives said that “the home and staff were great”.

Fifteen questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Five patients, two relatives and one member of staff completed and returned the questionnaires within the time frame. All responses were positive with regards to the management of medicines. One relative commented, “This is an excellent home.”

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.

Written policies and procedures for the management of medicines were in place. They were not reviewed at this inspection.

There were arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and were aware that some incidents may need to be forwarded to the safeguarding lead.

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 manager, registered nurses and the care assistant, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. All staff were complimentary about the management team.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with the staff concerned.

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 Ms Mary Jane Sagayno, 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 QIP to pharmacists@rqia.org.uk 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:** 1 July 2017	The registered person must ensure that medicine doses are not omitted due to being out of stock.
	Response by registered person detailing the actions taken: This concern has been raised with all the Registered Nurses through the supervision process. A recent audit reveals that there has been no omission due to a medication being out of stock. The Home has also liaised with the contracted Pharmacy in order to resolve this issue.

Please ensure this document is completed in full and returned to Pharmacists@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews