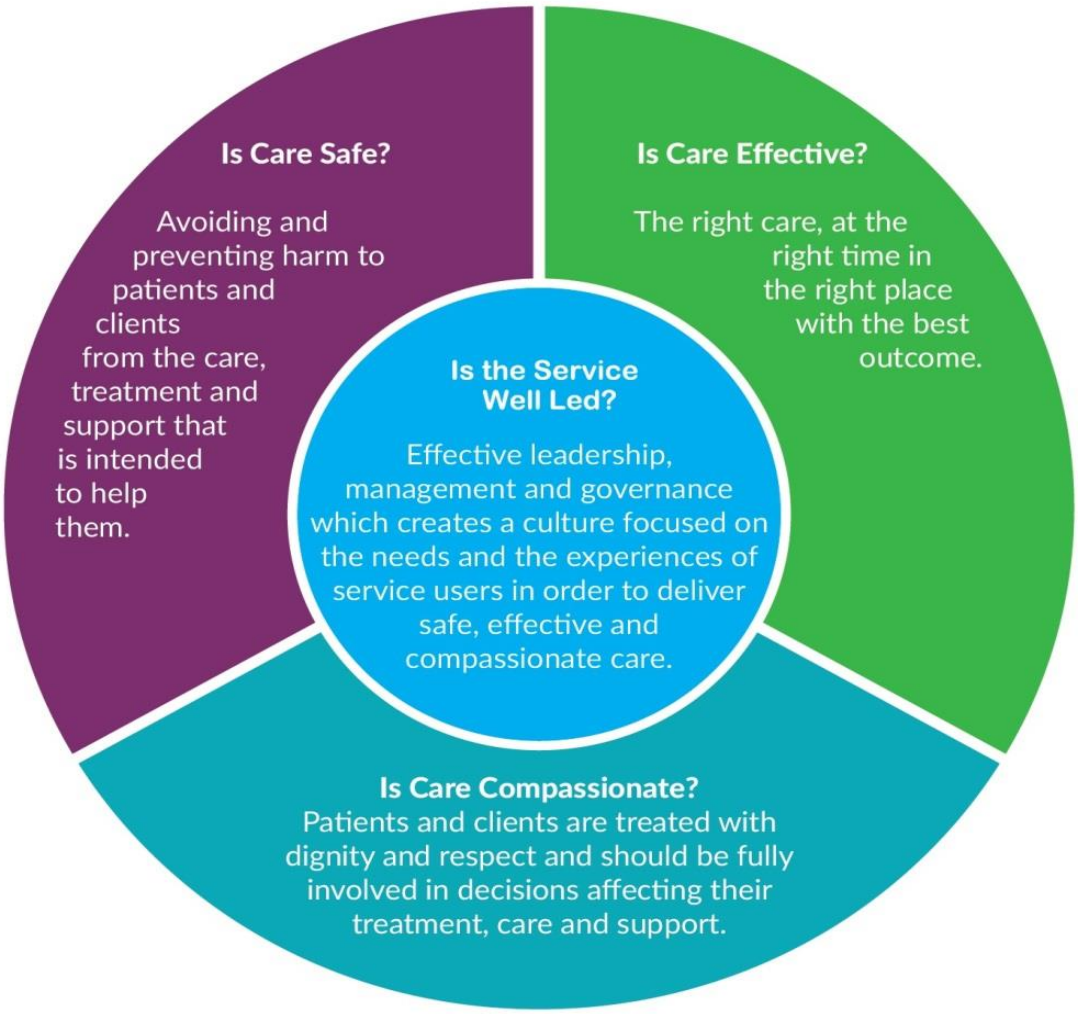
Unannounced Medicines Management Inspection Report
8 May 2018

St Francis

Type of Service: Nursing Home
Address: 71 Charles Street, Portadown, Craigavon, BT62 4BD
Tel No: 028 3835 0970
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 25 beds that provides care for patients with healthcare needs as detailed in Section 3.0.

3.0 Service details

Registered Provider: Mrs Mary Bernadette Breen	**Registered Manager:** Mrs Laura Mary Bridget Lavery
Person in charge at the time of inspection: Ms Adelaide Hartley, Nurse in charge	**Date manager registered:** 17 October 2017
Categories of care: Nursing Homes (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment	**Number of registered places:** 25 There shall be a maximum of one patient accommodated within category NH-PH.

4.0 Inspection summary

An unannounced inspection took place on 8 May 2018 from 10.25 to 14.50.

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

Areas for improvement were identified in relation to verifying hand-written entries on the medication administration records and the management of warfarin.

The patients we spoke with were complimentary about the management of their medicines and the care provided 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

Details of the Quality Improvement Plan (QIP) were discussed with Ms Adelaide Hartley, Registered Nurse, as part of the inspection process. Findings were also discussed with Mrs

Laura Lavery, Registered Manager, via telephone call on 1 June 2018. 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 13 April 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 incidents register; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

During the inspection we met with several patients, the cook, three care assistants, the registered nurse and the proprietor.

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
- controlled drug record book
- medicine storage temperatures
- medicine audits
- policies and procedures
- care plans
- training records

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 13 April 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned. 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 6 November 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time	The registered provider must ensure that medication administration records are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: A review of the medication administration records and the outcomes of the audits indicated that the medication administration records had been accurately maintained.	
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** Second time	The registered provider must implement a robust audit tool and action plans which address any identified shortfalls.	**Met**
	Action taken as confirmed during the inspection: The registered manager completed audits at approximately monthly intervals. Any shortfalls were investigated and discussed with registered nurses for immediate action. Accurate running stock balances were maintained for medicines which were not supplied in the monitored dosage system.	

Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall investigate the apparent non-administration of two medicines for one patient. A report of the findings and action taken to prevent a recurrence shall be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The investigation was completed and the findings were forwarded to RQIA.	
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 18 **Stated:** First time	The registered person should review the management of distressed reactions to ensure that detailed care plans are in place. The reason for and outcome of each administration should be recorded.	**Met**
	Action taken as confirmed during the inspection: Care plans which included details of the prescribed medicines were in place. These medicines were used occasionally; the registered nurse advised that when they are administered the reason for and outcome of each administration were recorded in the daily care notes.	

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. Training was completed annually via e-learning. The impact of training was monitored through the audit process. Competency assessments were completed every six months or more often if a need was identified.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training was completed annually.

There were mostly satisfactory arrangements in place to manage medicines on admission and medication changes. Personal medication records were verified and signed by two registered nurses. However, the majority of hand-written updates on the medication administration records had not been verified and signed by two registered nurses. An area for improvement was identified.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. There was no evidence to indicate that medicines were omitted due to stock supply issues. 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.

Robust arrangements were observed for the management of insulin. The use of separate administration charts was acknowledged.

Warfarin dosage directions were received in writing and transcribed onto an administration chart. It was noted that some transcriptions had not been signed by two trained staff and obsolete dosage directions had not been cancelled and archived. Transcriptions should be verified and signed by two trained staff and obsolete dosage directions should be cancelled and removed from the medicines file. An area for improvement was identified.

Discontinued or expired medicines were disposed of appropriately. The registered nurse advised that 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. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The registered nurse was reminded that spacer devices should be individually labelled and cleaned/replaced regularly. Assurances were provided that this would be actioned following the inspection.

Areas of good practice

There were examples of good practice in relation to staff training and the management of insulin.

Areas for improvement

Hand-written entries on the medication administration records should be verified and signed by two trained staff.

The management of warfarin should be reviewed and revised.

	Regulations	Standards
Total number of areas for improvement	0	2

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 prescriber's instructions. 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 medicines were due.

The management of distressed reactions, pain and thickening agents was reviewed and found to be mostly satisfactory. Care plans for pain were not in place for a number of patients; the registered nurse advised that these would be put in place following the inspection and hence an area for improvement was not identified.

The registered nurse 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.

Medicine records were well maintained and facilitated the audit process. The majority of the personal medication records were printed. They had been verified and signed by two registered nurses at the time of writing and at each update. As identified in Section 6.4 hand-written updates on the medication administration records had not been verified and signed by two registered nurses.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines, including inhalers, which were not supplied in the monitored dosage system.

The registered nurse advised that when necessary 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.

	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.

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 the staff were familiar with the patients' likes and dislikes.

Patients were observed to be relaxed and comfortable. Some were looking forward to having their hair done. Lunch was being served in a relaxed manner. Staff and patients were having a jovial conversation over lunch. Assistance was being provided where necessary and patients were being offered choices to encourage them to eat.

The patients spoken to at the inspection advised that they were happy in the home and that staff were caring.

As part of the inspection process, we issued 10 questionnaires to patients and their representatives. Two patients completed and returned the questionnaires. The responses indicated that they were very satisfied with all aspects of the care in relation to the management of medicines.

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 the 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. Arrangements were in place to implement the collection of equality data within St Francis.

Written policies and procedures for the management of medicines were in place. These were not examined in detail.

The registered nurse advised that there were arrangements in place for the management of medicine related incidents. Staff knew how to identify and report incidents and were aware that medicine incidents may need to be reported to the safeguarding lead and 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 nurse and care assistants, 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 were complimentary regarding the management team. One member of staff said that "you could not get a better manager or owner, both first class".

Areas of good practice

There were examples of good practice in relation to governance arrangements and quality improvement.

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 Adelaide Hartley, Nurse in charge, and Mrs Laura Lavery, 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 29 **Stated:** First time **To be completed by:** 8 June 2018	The registered person shall ensure that hand-written entries on the medication administration records are verified and signed by two registered nurses. Ref: 6.4
	Response by registered person detailing the actions taken: All hand written entries will be verified and signed by two registered nurses.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 8 June 2018	The registered person shall ensure that the management of warfarin is reviewed and revised. Ref: 6.4
	Response by registered person detailing the actions taken: Wafarin doses to be verified and signed by two nurses each time INR blood results are reported.

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

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